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MEDICARE: A FIFTEEN-YEAR PERSPECTIVE

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

JULY 30, 1980

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MEDICARE: A FIFTEEN-YEAR PERSPECTIVE

WEDNESDAY, JULY 30, 1980

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m., in room 2168A, Rayburn House Office Building, Hon. Claude Pepper (chairman of the committee) presiding.

Members present: Representatives Pepper of Florida; Bonker of Washington; Bouquard of Tennessee; Evans of Indiana; Oakar of Ohio; Ferraro of New York; Grassley of Iowa; Hammerschmidt of Arkansas; Regula of Ohio; Whittaker of Kansas; and Hopkins of Kentucky.

Staff present: Charles H. Edwards III, chief of staff; Val Halamandaris, senior counsel; David Holton, chief investigator; Kathleen Gardner, professional staff member; Nancy Smythe, investigative researcher; and Walter A. Guntharp, Ph. D., minority staff director.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

The CHAIRMAN. The committee will come to order, please.

I do not think that in my 32 years of being a Member of Congress I have ever had more personal satisfaction in being at a hearing than I have today, with these two distinguished Americans, the Honorable Wilbur Cohen and the Honorable Wilbur Mills. They are here to advise and counsel with our committee and our country about one of the greatest pieces of legislation ever enacted in our country, for which they are primarily responsible, that of medicare.

Fifteen years ago, Congress took a significant step in implementing national health insurance for the aged with the establishment of medicare. All of us, young and old alike, should be thankful that medicare was created.

I said to these two distinguished gentlemen, that I thought not only the elderly but the people of America should build a Washington Monument type of eulogy to what these two men have done for our country, especially for the elderly people of our country.

What would the elderly people of the country be doing today to provide a measure of medical care for themselves were it not for medicare, which these two gentlemen are primarily responsible for? Older Americans are grateful for medicare therefore, but today we have come to hear from these knowledgeable men, suggestions as to what might be done to perfect that great instrument and to make it more effective as a means of providing decent and adequate health care for the people of this country.

We know the per capita costs of the elderly have increased at a greater rate than the costs tc the general public. When medicare was enacted, older Americans paid $445 per capita for health care in 1965, and today they are paying an estimated $2,500 per capita, an increase of 525 percent.

While health costs have increased, the costs of participation in the medicare program have also increased at a rapid rate. For example, deductibles have increased 350 percent.

In 1965, senior citizens paid the first $40 of their hospital bill; today they must pay the first $180 of their hospital bill and part B premiums have increased 220 percent, from $3 to $9.60 a month.

Whereas medicare once paid almost 50 percent of their bill, medicare is now considered to be paying less than 40 percent of the average senior citizen's health care costs. So in this hearing today our committee wishes to learn the primary problems of medicare, why all Americans' benefits have evaporated and what we might be able to do and should do to restore confidence in the program, and to make it more adequate to serve the purpose they contemplated when they initiated this great legislation.

If there are no objections, I will insert my prepared statement at this point in the record. Hearing no objections, so ordered.

[The prepared statement of Chairman Claude Pepper follows:]

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

I would like to welcome you here this morning as we observe the 15th anniversary of the enactment of the medicare program.

It seemed only fitting and proper that we call before us at this hearing two of the men who were most responsible for the enactment of this historic piece of legislation. I am proud to have the Honorable Wilbur Mills, former chairman of the House Ways and Means Committee, and the Honorable Wilbur Cohen, former Secretary of the Department of Health, Education, and Welfare, here with us today. We also have a panel of senior citizens and a panel of physicians who will give us their perspectives on medicare today.

It was 15 years ago that Congress took note that older Americans were sick three times as often, three times as long, and spent three times as much for health care at a time when, having retired, they had less than half of the income of their younger counterparts. Congress also learned that there was an abhorrent two-track system of medicine in America—one system for the poor and another for those who could afford to pay. Therefore, in the preamble to that historic piece of legislation, the Congress declared that good health care was the right of all Americans and that there should be no discrimination as far as access to health care based on ability to pay.

This covenant we made with the elderly of this Nation. The question is: Have we kept the covenant?

Over the past few months, we have sought the opinions of thousands of older Americans. Most of them tell us that they are grateful for medicare, however, they feel that medicare's benefits are slowly evaporating. They point out that while per capita health costs for all Americans have increased 395 percent from 1965 to the present, per capita costs to the elderly have increased about 500 percent. They point out that it is costing them 220 percent more for medicare's part B premiums and that copayments and deductibles have increased 350 percent. They note that while medicare was paying almost 50 percent of their health care costs when it began, it now pays something like 40 percent of their bills—or less.

Senior citizens feel they are paying more and more and getting less and less for medicare—and there is strong justification for this conclusion. The burden of care for the aged is more and more being shifted from medicare, which is a program of universal entitlement, to medicaid, the welfare program for the aged, blind and disabled who share the common denominator of poverty.

We have learned that much of medicare's acceptance in the past grows from the fact that, like social security, the elderly believe they pay into the trust fund in their younger days so that they might benefit in old age. Medicare, they feel, is a

vested right that they have worked for, while medicaid is a handout. Many seniors will go without care rather than accept the stigma of going on welfare.

Our studies suggest the following as the major issues in medicare at the present time. I hope to have some discussion of these issues today. First, the growing gaps in medicare. There is no coverage for drugs, eye care, dental care and limited coverage for home health care.

The fact that medicare's nursing home program has been allowed to be cut back is one factor in creating the second major problem: overutilization of hospitals. We are keeping thousands of older Americans in hospitals longer than necessary because we cannot find a place for them.

The third problem which we must address is the growing refusal of physicians to accept assignment. Under the law, doctors may either bill medicare and accept what it pays—this method is called accepting assignment—or they can bill the patient and let him/her collect from medicare. It goes without saying that when the physician does not accept assignment, the patient must pay more as well as carry the burden of medicare's paperwork.

The Congress is close to enacting legislation to expand home health coverage and to allow per capita payment for medicare beneficiaries who choose to participate in an HMO. We have sponsored these proposals here in this committee. However, we must do more. Another idea which I have advanced would allow those physicians who accept assignment from all their patients to deduct a certain amount of their receipts from their federal income taxes.

I have also advanced the idea of creating a new part C of medicare. The program would be voluntary like medicare part B and funded by a premium equal to part B. Additional revenues would be carried by a small excise tax on cigarettes and alcohol. Congress could, in effect, authorize a comprehensive medicare supplemental health insurance policy which would cover eyeglasses, dental care, hearing aids and out-of-hospital prescription drugs. The measure would essentially be self-financing. Taken together with the other proposals I have outlined above, it would offer senior citizens, for the first time, something approaching comprehensive coverage.

I would be interested in any comments on these issues and proposals. I believe the Congress must act and act soon if we are to prevent medicare from becoming another broken promise made to the elderly.

The CHAIRMAN. Now I would like my colleagues to make any statement they would like to make. First Mr. Grassley.

STATEMENT OF REPRESENTATIVE CHARLES E. GRASSLEY

Mr. GRASSLEY. Mr. Chairman, medicare is 15 years old this year. It is a nondiscriminatory program in that almost everyone over the age of 65 is eligible for medicare. In conjunction with medicaid, it is virtually free to those who are unable to pay the modest fees and insurance premiums associated with its medical and hospital services. For the elderly poor, the blind, the disabled, and for needy families, the medicare-medicaid combination provides a near equivalent to universal health care.

Among the purposes of today's hearing is to assess the medicare program for gaps, flaws and shortcomings. The responsibilities with which our committee is charged demand that we do this with diligence and with a great sense of compassion for the millions of older Americans who benefit by the extent of medicare coverage or who suffer by the extent of its limitations.

We must also remain aware of the relationship between the expansion of federally provided medical care and the tax-supported costs associated with these benefits. Thus, we must be objective as well as compassionate because the future financial health of the medicare program depends on careful long-term consideration of each modification we make in it. We must not damage the future solvency of the program by an excess of good intentions as has been the case in the social security program.

One thing we can and must do is to clean up medicare management. In fiscal year 1977 alone, HEW Secretary Califano revealed

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that mismanagement accounted for the loss of $2.2 billion through fraud, waste, and abuse in the medicare program. Since then, there is little evidence that such loss has been reduced and there is some evidence to suggest that the annual loss is much greater now than it was 3 years ago. It is obvious that the recovery of these funds would enable a considerable expansion of the program at no additional cost.

Mr. Chairman, I am particularly impressed with the stature and quality of our witnesses today and I join you and my colleagues on the committee in looking forward to their testimony.

The CHAIRMAN. Thank you.

Mr. Hammerschmidt?

Mr. Hammerschmidt, I think, would like the honor of also making a presentation of one of our distinguished witnesses today.

STATEMENT OF REPRESENTATIVE JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you very much, Mr. Chairman.

You already know what high respect and great regard I have for the Honorable Wilbur Cohen. He has appeared here as a witness before. But as you say, we are doubly honored this morning to have these two men here, the other Wilbur, the one we have all known and loved for years past.

Mr. Chairman, I want to thank you for this opportunity to say a few words about a man whose achievements I admire and whose friendship I hold dear, Wilbur Mills. He was the dean of our Arkansas delegation during my first 10 years in the House. I feel very honored. Certainly he helped me as my mentor as I came here and learned about the House of Representatives.

Anyone who has been involved in the legislative process will admit that the transition from substantive social policy into law cannot be attributed to any one person. Participants in a complex issue such as comprehensive health insurance include Presidents, key administrative staff, members of both House and Senate committees, party leadership, special interest groups, and public sentiment. There are individuals, however, who are able to sense changing public attitude, untangle disparate ideas and orchestrate new legal concepts. Wilbur Mills is such an individual.

Demands for the Government to become involved in health insurance go back to the first decade of the 20th century, and comprehensive insurance bills date back to 1935. For the following 30 years there were debates about the need for any such program, who the beneficiaries should be, what benefits should be included, and how any health program should be financed.

In 1964, when Wilbur Mills was chairman of the House Ways and Means Committee, there were three very different bills under consideration—one offered by the administration, the Byrnes bill offered by the ranking member of the committee, and the American Medical Association's alternative, called eldercare.

Mr. Mills worked with all the members of the committee, he also consulted with administration officials, groups representing doctors, dentists, nurses, hospital administrators, labor leaders, and representatives of the insurance industry.

Theodore Marmor, a special assistant to Mr. Wilbur Cohen, wrote in his book "Politics of Medicare," "throughout, Mills left no doubt that he was first among equals—he acted as the conciliator, the negotiator, the manager of the bill."

The result of Wilbur Mills' effort was remarkable; he found a way to combine what had been considered three mutually exclusive solutions into one bill.The administration's proposal, the hospital insurance program, became part A of the new medicare bill. A modified Byrnes proposal of voluntary doctors insurance became part B of medicare. And, the AMA proposal, which was intended as a substitute to medicare, instead expanded previous health legislation and became title XIX—what we refer to today as medicaid. His skill culminated in a final legislative package that incorporated all the major alternatives before the committee.

The new bill had features that no one else had foreseen and was politically invulnerable. When the House met on April 8 on what was referred to as the "Mills bill," they gave the chairman a well-deserved standing ovation.

Now I have shared this brief history with you so that we may all better understand how we arrived at our current legislative juncture and also to give you a keener sense of the man who helped deliver this extraordinary package. An achievement of this magnitude came about by a series of compromises, bringing consensus out of conflict.

We are all aware that there is still more to be done, Mr. Chairman. I think we are extremely fortunate to have his further guidance as we attempt to make medicare more responsive to the needs of the growing elderly population. So I want to warmly welcome our distinguished former colleague Wilbur Mills, as well as our distinguished great member of the executive branch, Wilbur Cohen.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Whittaker.

STATEMENT OF REPRESENTATIVE ROBERT WHITTAKER

Mr. WHITTAKER. Thank you, Mr. Chairman.

I first want to commend you for arranging these hearings today, on a very important subject, the medicare program.

While I know millions of older Americans have benefited from this vital program during its 15 years of existence, there are also thousands that have suffered hardships because of the gaps that exist in the program.

As I travel around my congressional district in Kansas and talk with our older Americans, the message I get is that inflation is still the No. 1 problem facing them. They cannot afford the day-to-day necessities, let alone the larger expenses such as medical care, which can completely deplete their budgets.

Day after day I receive letters from older constituents who are shocked to discover that a medical expense they thought would be covered by medicare will not be. And unfortunately, they usually don't discover this until after the expense has been incurred. I am sure my colleagues share the same frustration I do when I must explain to my constituents that their claim has been figured cor-

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rectly and the medical bill they have acquired is in an area not covered by medicare.

I am very much aware that attempts to fill these so-called gaps in medicare and to provide broader coverage almost inevitably will mean raising the cost of the program. That makes our task all the more difficult because I know we all would like to provide the best possible coverage while still keeping the cost in line. It won't be easy. As so many of us are aware, health care expenditures since 1950 have increased 1,250 percent and they are slated to continue rising.

These increases only make our task more difficult. However, I trust that hearings such as this one today will help us all to address this problem and review possible reforms in the medicare program. In the process, I hope we will not ignore the critical need to communicate to the older Americans just what the program is, what expenses it will cover and how it will help them. Steps such as this will be advantageous not only to today's older citizens but also to those who will some day need the help of medicare.

The CHAIRMAN. Thank you.Ms. Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. OAKAR. Thank you, Mr. Chairman.

I would like to submit my entire statement for the record.

[The prepared statement of Representative Mary Rose Oakar follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

I want to commend our Chairman, Senator Claude Pepper, for holding this hearing today to evaluate the strengths and weaknesses of Medicare on its 15th anniversary. I also want to applaud the superb Committee Report, "Medicare After 15 Years: Has It Become a Broken Promise?"

Letters to the House Select Committee on Aging, surveys, and the thousands of reports from my own constituents indicate that the vast majority of our senior citizens view Medicare as valuable and necessary. However, many of these same people also feel that Medicare has not lived up to its potential. When Medicare was created in 1966 it was hoped that no senior citizen would be denied medical care for reasons of cost alone. Government would share the burden of payment. Over the last 15 years, though, the escalating cost of Medicare has meant that our seniors have actually had to pay more to participate in the Medicare program. For example, in 1966 the per capita health care bill for older Americans was $445 per year. In 1977 the per capita health care bill for older Americans had increased by 300 percent to $1,738 per year. While much of this increase has been absorbed by Medicare, the average out-of-pocket expenses for every older American averaged $562 per year in 1977—more than the total health care bill for every older American in 1966. In this day of double-digit inflation which bears down so hard on our seniors who must live on fixed and limited resources, this increase is unacceptable.

The report details other difficulties confronted by the elderly under Medicare, and they are confirmed by the many thousands of cases my district office handles. The shifting of the burden of payment from Medicare to Medicaid, a means-tested program, reduces the Federal tax burden but also forces seniors in many instances to pay more while also placing them in the category of welfare recipient. Equally as disturbing is the overutilization of hospital services because nursing homes are reluctant to participate in Medicare.

Another area of concern to many of my constituents, and which is highlighted in the report, is the fact that so few doctors accept assignment. Today only one-half of physicians accept assignment, while 66 percent of the physicians accepted assignment in 1966 when Medicare first began. The failure of Medicare to adequately cover expenses for eye glasses, hearing aids and dentures, medical appliances that millions of older persons must have to function adequately, is another serious deficiency. Because of these shortcomings, our Nation's tax dollars are sometimes wasted while the high expenses for medical care and the gaps in the Medicare

program force our seniors either to forego medical treatment or sacrifice other necessities in order to receive it. This, too, is unacceptable, and raises the question of whether Medicare has become a broken promise.

Our senior citizens are the best judges of the strengths and weaknesses of the Medicare program. I would like to represent my own senior citizen constituents by citing one of the many thousands of cases handled by my district office. Mr. Arthur Wilhelm is one of the millions of senior citizens who do not receive adequate reimbursement for their medical care provided under Medicare Part B.

As is all too common, the full amount of billed services was not approved for 80 percent coverage under Medicare Part B. However, in the case of Mr. Wilhelm, the Medicare intermediary had previously approved the same amount for the identical medical service provided in April and May of this year. What I found to be astounding was that the Medicare intermediary explained that as of July 1, 1980 the approved amount for house calls by physicians had been decreased. Mr. Wilhelm is fortunate enough to have a doctor who will make a house call and charge his cachester for only $18 a visit. But as of 1 July the allowable charge is $10 per visit. Where will Mr. Wilhelm find a good doctor who will make a visit for only $10? This is but one of the innumerable cases our office handles regarding low reimbursement for Medicare Part B services.

Medicare currently assists our elderly with about one-third of their medical needs. Preventive health care is not comprehensively addressed. Therefore, I want to announce my support for the recommendations appearing in the committee report. I have just spoken with the Senator this morning, and also want to announce my wholehearted support for his Medicare reform package. This package will fill a serious gap in the Medicare program by creating a new Part C. The proposed Part C will provide older Americans with the comprehensive coverage they need and deserve, and has the additional virtue of being practically self-financing. I am pleased to be able to serve as a prime co-sponsor of this necessary and valuable legislation.

Ms. OAKAR. I certainly commend you and other members of the committee for having this hearing.

I also want to say that I think the committee report on medicare after 15 years is absolutely superb. I just want to say that one of the things that, as we celebrate this 15th anniversary—there are a couple of concerns that I have.

One is that, as stated in the report, so few doctors today will accept medicare assignment. I notice many senior citizens are turned down very often. We found, according to the report, in my own research that only one-half of the physicians accept assignments today while 66 percent did when it began in 1966.

The other concern I have is that the intermediaries, at least in my district, are arbitrarily lowering the reimbursements for my constituents. They are making value judgments and I cite in my testimony several examples of this, whereby they will pay, for example, for a personal house call $10 that will only reimburse the elderly person for $10 a visit when in fact it may have cost this individual $25 or more. This I think is very, very tragic. I think we ought to really look into who is making those kinds of decisions.

Finally, I would certainly like to announce my support for the medicare reform package. I think your concept, Mr. Chairman, of adding a new part C to deal with the fact that under the current law medicare, while it began—and we owe so much to Wilbur Cohen and some of the others here—it really does only cover about a third of our older people's needs, that we really aren't dealing comprehensively with preventive health care and all the kinds of needs that we associate with growing older, such as eye care, ear care, foot care, medication coverage. So I certainly want to announce my support for the medicare reform package.

I also want to just briefly say how delighted I am to have these two distinguished witnesses. We all know Chairman Mills' background and the wonderful work he did on our Ways and Means

Committee. I didn't have the pleasure of serving with him. I look forward to hearing his testimony.

Somebody is going to write a play one of these days about the many hats of Wilbur Cohen, because he not only knows more about the Social Security Act than any other chairman, but he also is my chairman of the National Commission on Unemployment Compensation, on which I am pleased to serve under his leadership. I think we are very fortunate to have such distinguished individuals to testify before our committee today.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Oakar. Mr. Bonker.

STATEMENT OF REPRESENTATIVE DON BONKER

Mr. BONKER. Thank you, Mr. Chairman.

I have a statement I would like to have included in the record, and I will just offer a few opening comments.

[The prepared statement of Representative Don Bonker follows:]

PREPARED STATEMENT OF REPRESENTATIVE DON BONKER

Mr. Chairman, I would like to commend you for calling this hearing on the 15th anniversary of the enactment of medicare. Health care for the aged is an extremely important topic. It is the one subject in the field of aging that I am most concerned about.

I think that most of the members of the Committee know that I had a small role in bringing about the enactment of medicare. I served on the staff of the Senate Committee on Aging in 1964 and 1965.I remember the fight. I remember the prophets of doom. I remember the joy that we had and I remember the lingering concerns which weighted our best hopes for the program's success.

In retrospect, I agree with you, Mr. Chairman, that medicare has been a real blessing for older Americans. I know that older Americans are grateful for it. I think medicare has served to bring senior citizens into the mainstream of American medicine.Before the enactment of medicare there was a two-track system in this country—one for those who could pay and another for the poor and elderly.

I have been fortunate to chair four hearings on medicare in the past two years. At these hearings we heard from literally hundreds of older Americans. I have the strong impression that today we are at high noon with respect to medicare. I think seniors would be evenly divided on the question of whether they are happy with medicare. I think the tide is running strongly in the direction of dissatisfaction. My constituents tell me that fewer and fewer physicians will accept assignment and that medicare is slow in making payments and that medicare does not pay enough. Senior citizens ask why it is that they must pay the doctor in cash and then have to wait for months for repayment.

At our hearing in San Diego, California, senior citizens outlined their dissatisfaction with the interpretation of the term "reasonable charges." One man gave us a case history. He said the physician charged $5,000 and medicare determined $1,000 was reasonable. Medicare then paid 80 percent of what was determined reasonable, or $800. He said he felt cheated. He felt the government and physicians were taking advantage of the aged.

At another hearing in Longview, Washington, we proved that our current policy to cutback payments to medicare nursing homes has resulted in keeping patients longer than necessary in hospitals at four times the daily cost to the government. We estimated the cost to the nation from this myopic policy may be $1.5 billion a year.

At a recent hearing in Connecticut we heard about the growing gaps in medicare and their effects on senior citizens who often ignore obtaining the medical care they need because they cannot afford it.

Mr. Chairman, it is clear to me that medicare is sick. These hearings will help us to begin to diagnose the problem and then we must begin reforms. I think that an in-depth look at medicare problems is in order and I have asked the chairman to form a task force for this purpose. I also think we need to examine reform proposals. I think we must make an effort to provide older Americans with the health care that they need and deserve. I have introduced a bill, H.R. 4168 with this purpose in mind. I think that it is imperative that we act and act soon if we are to keep the

promise we made to our nation's elderly in the preamble to medicare where we declared that good quality health care is the right of all Americans.

Mr. BONKER. I would like to commend you, Mr. Chairman, and your fine staff for both the hearing and the draft report that is before this panel, and also thank the two witnesses who are truly the giants in this field. You honor us by your presence. We are looking forward to your comments on what has become a continuing issue, this issue of health care for senior citizens.

I worked on the Special Committee on Aging on the Senate side in 1964, with Jay Constantine, as this bill was being developed. At the time it held much greater promise than the reality has borne out.

The statistic I see is that medicare presently covers only about 38 percent of all the health care related expenses of senior citizens. Not only that, but there are also many complications for senior citizens in dealing with medicare.

We have been conducting hearings on a subject not very exciting but terribly important. That is the problem of senior citizens trying to go over medicare statements to figure out who pays what. Medicare covers a portion, supplemental insurance a portion, the patient a portion—it is a very complicated procedure indeed.

When enacted, medicare was not only supposed to provide coverage for senior citizens, also streamline the whole health delivery system in the country. Acute care would be provided in a hospital, then when ambulatory, the patient moves into what we called, at that time, an extended care facility for recovery purposes. The patient then moved home for home health care service.

That care continuum would lower the cost of the program by moving the patient from hospital to nursing home to home or home health care. But now we are seeing the tremendous gaps that exist in this system. In one set of hearings in Longview, Wash., we found that nursing homes were not accepting medicare patients for a variety of reasons. They had the beds but were not accepting the patients. That meant either the patient's hospital stay was prolonged, thus costing more, or that patient was, in effect, denied the benefits to which he or she was entitled under medicare. We have no answers to these problems but we have the gaps.

I would like to say that I think the two national health care proposals that are part of the national debate are pretty much outside our reach, economically speaking. Even progressive Democrats have recognized we can't place another $70 or $80 billion burden upon the budget. Tinkering with the whole health delivery system in the way envisioned by two national health insurance proposals also seems unwise.

Senior citizens remain the victims of today's health process; most people who work are properly covered by group insurance. They get adequate coverage. The poor get adequate coverage through medicaid. But the senior citizens are the victims because they get only partial coverage under medicare. To augment this partial coverage they buy this supplemental insurance, much of which is worthless. I hope when we focus on this subject of national health care that we try to look for other alternatives.

My own approach, which is in draft form and has been introduced as H.R. 4168, would greatly expand the present medicare

program to make it more comprehensive. Parts A and B would be expanded to provide more comprehensive coverage and a new part C would provide coverage for prescriptions, eyeglasses, and so on.

I hope H.R. 4168 will be another alternative that we can consider when we talk about national health care, particularly health care for senior citizens.

Thank you, Mr. Chairman. I am really looking forward to the witnesses we have today.

The CHAIRMAN. Thank you.

I have before me some additional prepared statements submitted by our colleagues. If there are no objections, I will offer them for the record at this time. Hearing none, so ordered.

[The prepared statements of Representatives William R. Ratchford, Ralph S. Regula, and Larry J. Hopkins follow:]

PREPARED STATEMENT OF REPRESENTATIVE WILLIAM R. RATCHFORD

Mr. Chairman and distinguished members of the committee, I am pleased to have the opportunity to reflect upon the Medicare program over the last fifteen years and to reiterate my support of the legislation to expand home health coverage which is close to being enacted.

My experience in the aging field tells me that the value in extending the elderly's access to home health care is a very real and desirable alternative to institutionalization. This point cannot be understated.

Since the enactment of the Medicare program in 1965, millions of our nation's elderly and disabled have been able to protect themselves against financially debilitating and catastrophic illnesses. Though well-intentioned, the program has now reached the unfortunate stage at which the elderly must now pay more for health care than when the program was first adopted 14 years ago. Costs are once again locking the elderly out from the medical care they so desperately need. The system has developed many problems, which this committee is so boldly examining. The current program of coverage either denies benefits to many of our 24 million elderly citizens who need it most, or provides little in the way of benefits for acute or chronic illnesses.

President Lyndon Johnson documented the special health care needs of the elderly in his February 1963 Special Message. He reported that "The elderly are sick more frequently than the rest of the population. Of every 100 persons age 65 or over, 80 suffer some kind of chronic ailment, 10 impaired vision, and 17 have hearing impairments. Sixteen are hospitalized one or more times annually." Approximately 7 million elderly today urgently require home health services of some kind to avoid either costly and inappropriate consignment to nursing homes, or unnecessary hospital stays required to ensure benefits. Despite this clear demonstration of need, we have failed in our commitment to extend the availability of in-home care to underserved areas. Though we have time and again highlighted the need for expanding access to home health services through such agencies, there are still some 650 counties, where almost 10 million people live, that do not have a Medicare-certified home health agency.

In 1977, less than 3 percent of medicare's expenditures, or $493 million, could be attributed to home health care benefits. Efforts to liberalize these benefits, as embodied in H.R. 3990, is a major step toward meeting the total health care needs of our elderly, and toward making the medicare program all that it should be.

Let me now turn to the specific provisions of H.R. 3990. First, the legislation would increase the number of home health visits allowed under both Parts A and B of Medicare. Presently, beneficiaries are only eligible for 100 visits during the year following a qualifying inpatient hospital stay under Part A, and only 100 visits per calendar year under Part B. This restriction, Mr. Chairman, prevents the delivery of health care on a need basis. This restriction forces the elderly to turn elsewhere after they have exhausted the limit, though they continue to require care in the home. Most often, either institutionalization is then required or Title XX funds are sought. The latter alternative has had the effect in many instances of shifting the nature of coverage from health to social services benefits, when indeed the health care need should be pre-eminent.

In that Medicare requires the administration of skilled nursing or professional therapy care, many cannot even maintain eligibility until the 100 visit limit has been exhausted. This skilled care requirement precludes many preventive and main-

tenance services required to keep the elderly out of hospitals or other institutions. Most importantly though, is the fact that so many of our elderly are subject to chronic long-term illnesses, and often the 100 visit limitations under Parts A and B do not allow sufficient time for the person to recover. Though the estimated cost of the elimination of the 100 visit limits is high, in the long-run I am confident we could demonstrate a savings by providing a more attractive and less costly alternative to institutionalization. In its 1977 Report to the Congress entitled: "Home Health—The Need for a National Policy to Better Provide for the Elderly," the General Accounting Office estimated that this action would cost an additional $12.5 million for an anticipated increase of 300,000 visits per year, or a 2 percent increase in home health benefit costs. This estimate assumes that about 3,000 people would exhaust Part B benefits and use an additional 100 visits a year, which is very minimally the case.

A second major provision of H.R. 3990 would eliminate the three-day prior hospitalization requirement under Part A. Presently, the 1.1 million Part A—only beneficiaries do not have access to this home care benefit unless they have been hospitalized for three consecutive days. I'm afraid that, contrary to the conclusions of the previously mentioned GAO report and the claims of the Department of Health, Education and Welfare this requirement clearly has led to a pattern of physicians unnecessarily admitting patients into a hospital not to administer the most cost-effective care he or she knows how, but merely to comply with the law. This added expense comes at a time when over 75 percent of Medicare expenditures have been made for hospital and nursing home care. It is unfortunate that the medicare program is still patterned after traditional health concepts, which purport that if we merely treat a patient, he or she will get better. The reality of today's growing elderly population is that they are more fragile than others, and require unique and longer care for their chronic illnesses. A vivid example comes quickly to mind: The arthritic patient that generally needs sustained and skilled home care, yet does not require three days hospitalization. GAO has estimated that the cost of eliminating the three-day prior hospitalization provision would be $12.5 million, but again the costlier alternative of hospital care or institutionalization would dictate a real long-run savings.

These are very positive steps, yet I would propose that we go farther in meeting the home care needs of the elderly. I submit to you today, that the next action of this committee in the home health field must be to develop means of fostering better coordination between the many federal, state and local agencies which provide or administer home care services. If I may indulge the committee one moment, I would like to point to two nationally acclaimed programs developed during my tenure as Commissioner on Aging in Connecticut, to ensure that new home health services provided at the local level are indeed delivered in the most cost efficient manner and based upon individual needs.

The notion of a new mechanism for case management derived from a largely federal funded demonstration research program called Triage. Now concluding its service and study, the Triage experiment tested the provision of appropriate care for Medicare-eligible persons by focusing on alternatives to inappropriate institutionalization. The action component of Triage made assessments of client needs and arranged for services to follow up on existing service agencies. Via special arrangements, Triage was able to make available a wide range of services using Medicare funds to some 1550 clients in 1978 in seven central Connecticut towns. The research component of Triage is under the direction of the University of Connecticut Health Center, and is now completing its study of client health status, client functioning in daily living activities, and on the costs of care.

Connecticut's other fine program is SAIL (Strengthened Assistance for Independent Living). This home care development program provides home care service to functionally impaired older persons to avoid unnecessary care in nursing homes. Using both state and federal Title XX funds, SAIL has developed a service plan based on individual needs and then purchased those services for clients from the appropriate agencies, after making maximum use of family and other resources. Preliminary figures show that the average cost per SAIL client of $240.60 per month is 75 percent below the State Department of Social Service's average approved Medicaid rate for care in a skilled nursing facility, which is $989.80 per month.

These pilot programs in Connecticut demonstrate the effectiveness of home health service coordination. Such "Coordinating Assessment and Monitoring Agencies" or CAM's could serve as a legitimate Medicare provider and in a systematic way tend to the assessment, monitoring and coordination functions of home health care. I urge the committee to further examine the lead that Connecticut has provided in this area.

At this point, Mr. Chairman, I would like to sincerely thank the Committee for this opportunity to explore whether the covenant between the Congress and our older Americans has in fact been kept.

PREPARED STATEMENT OF REPRESENTATIVE RALPH S. REGULA

Mr. Chairman, I appreciate the opportunity to participate in this hearing on the fifteenth anniversary of Medicare.

The purpose of the Medicare law is to extend to the elderly the best possible health care services in a cost-effective manner. Medicare has been a significant benefit to the elderly of our country. However, with the rising cost of medical care and the population growth of persons over the age of 65, there are serious gaps in Medicare coverage for many people.

I have been concerned about the need to provide better home health care services as an alternative to institutionalization for the elderly. I believe we can provide health services in a more cost-effective manner through improved services to the elderly who wish to remain in their home environment. I can certainly sympathize with those who want to stay in their home as long as possible and avoid the more costly care of a hospital or nursing home. Improving the delivery of services to the elderly in their homes will enable them to remain more independent and self-sufficient for a longer time.

I will be looking for provisions dealing with home health care, as well as other reforms, in the proposed Medicare legislation.

PREPARED STATEMENT OF REPRESENTATIVE LARRY J. HOPKINS

I would also like to join in commending our chairman for scheduling this hearing on the Medicare system on this, the 15th anniversary of the enactment of the Medicare program.

So much has changed since 1965 in our country—that it is appropriate to re-look at the Medicare program and how it is operating and how it can be improved. America has changed and older Americans have changed. We need a Medicare system that responds to these changes and meets today's needs.

The rising cost of medical care causes enormous problems for consumers, but no segment of the population is more adversely affected by health care cost inflation than the nation's elderly. Although the aged represent just over 10 percent of the population they are responsible for over 25 percent of all personal health expenditures. Those over 65 pay more out of pocket for their medical care today than they did in 1965 when the Medicare program was founded. I was surprised to learn that from a high of 50 percent in 1969, Medicare now pays for only 38 percent of the total medical bill for our nation's senior citizens. The rest of these expenses are paid either directly by the elderly patient, by various publicly funded medical assistance programs such as Medicaid, or by private health insurance.

Nor is our system geared to providing the type of health services most needed by our older population. Medicare coverage is geared to meeting the costs of acute illness—health services for those who will eventually get better. Unfortunately, many elderly people will not get better, they will stay the same or their health will gradually deteriorate. The National Center for Health Statistics estimates that 81 percent of all persons over 65 have chronic conditions—conditions which won't go away. And it is still true in our country that a person who needs long term health care must deplete all of his personal resources and become basically indigent in order to receive assistance for long term nursing care.

These are some of the topics which I hope will be explored in today's hearing. I look forward to the testimony of our witnesses, and also want to commend the Chairman and the committee staff for their fine work in putting together the excellent Committee report on this subject.

The CHAIRMAN. I won't spell it out too much, but we all heartily join in what was said by Mr. John Paul Hammerschmidt, the distinguished representative from Arkansas, as Mr. Mills once was, for the great tribute that he paid to former Member Mills.

One of the ways I have advised young people to try to fashion their lives is to try to live such a life so that when you come to the upper ages of life you will be able to look back and say, well, I did something to make it possible for a whole lot of other people to

walk on higher ground, live a little healthier, happier, better lives. That is exactly what you two men here have done.

There never was a master of legislation more appreciated and more perfect in his mastery than Wilbur Mills was in the House. He had the unerring instinct of being able to look over that House, determine whether he could pass his bill or not. If he couldn't pass it that day, he would carry it over until the next week when his keen sense perceived that the psychology would be a little better to take it up at that time.

I shall never forget how he used to, as we would say, sometimes "hold court" out in the Speaker's lounge. He would go out there and sit down on the sofa and smoke, and Members would take advantage of that opportunity to come and sit down by Wilbur Mills. They just wanted the delight and honor of sitting there talking to Wilbur Mills, and also to be seen talking to him. Of course he was the most acclaimed, and generally speaking in terms of legislation, the most powerful Member of the House.

Wilbur, I have always considered you entitled to major credit for SSI. I know both of you contributed on that, when you wisely determined that the Federal Government ought to take over that responsibility, make it uniform throughout the country, instead of the State having all these vacillating figures that they had. So medicaid, medicare, SSI, if men had never done anything in their lives but have a part in fashioning those great institutions, what a happy recollection that will provide.

So I just want to say in conclusion that for his great achievements in the legislative field, for his personal courage and character, he has the respect, the gratitude and the affection of the American people, Mr. Mills.

Mr. Mills, we invite you to make the opening statement if you wish.

STATEMENT OF HON. WILBUR MILLS, FORMER CHAIRMAN, WAYS AND MEANS COMMITTEE, U.S. HOUSE OF REPRESENTATIVES

Mr. MILLS. Mr. Chairman, I am overwhelmed, I am at a loss of words to respond to your very generous statements, those of my former colleague from Arkansas, Mr. Hammerschmidt, and the other members of the committee.

I want to commend you for the great interest that you have had over the years. I can think back to the time when you were in the Senate and I was a freshman Member of the House and the interest you have had in the problems of our elder citizens, particularly the health problems of our elder citizens.

I also thought when we passed legislation in 1965 that we really should have called it the Claude Pepper proposal, because you came out very early, as I remember, in advocating proper health care for all of our citizens. Here we were concerned with the problems of our senior citizens, those on welfare, those under social security, and under railroad retirement.

You will remember we had passed earlier a law referred to as the Kerr-Mills Act, which limited its help to those on welfare. All the States responded to the program and set up a health program for people on welfare.

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So I say that really we are still in the process of improving the health care and the problems of our older citizens and of our citizens generally in the field of health care. We still have this great void that exists among people, depending upon their age and economic circumstances.

I want to commend the committee, therefore, for the interest that you are showing; I want to commend you for this hearing today, and certainly for the thought that you have advanced in part C for medicare.

I feel totally inadequate to talk to you about any weaknesses in the program. You know, when you author a program, you expect it to be perfect. I thought it was. I thought it would take care of the costs of the medical problems that older citizens would encounter.

I remember when the administration first suggested, and Wilbur, you remember this, the first suggestion was for the care of the patient in the hospital. We figured out that that would represent about a fourth of the total cost to the older people of medical problems.

It was necessary, we thought, to enlarge upon that. How we would do it was the big problem. The doctors, of course, were very concerned about being paid out of the withholding system. They didn't want that. So we have to give John Byrnes, the ranking Republican member of the committee at the time, credit for plan B as we know it today. Plan B added a tremendous amount of services to those in need of medical care 65 years of age and older.

The committee came out with a bill that we thought generally would, in perpetuity, take care of the major costs that would be encountered by these people. We never envisioned anything such as we are hearing today of the small percent of the total costs that are being paid by this program.

We did not fund it properly to begin with; that is part A.

We have had some troubles with part A ever since the first funding. We started off with I believe 0.7 funding, combined tax on employer-employee. It should have been about 0.9.

Within 2 or 3 years we found that the costs had risen much faster too than we had anticipated. So that we were in trouble then and we remained in trouble for some time with the fund, and I assume we are still in trouble in the financing of it.

But so far as the services are concerned, we could not think of any service, frankly, that we had left out of either part A or part B. The division of the payment, things of that sort, we worked out, trying to accommodate the wishes of those who would supply the services. We tried to take care of the doctors' feelings that we were socializing them, and so on.

I must say that after 15 years of the operation of the program, one of the things that we can point to with a great deal of pride is that we still do not have socialized medicine in the United States, the fear that was expressed.

Now if I could answer questions of the committee, perhaps I could think of something that I might say that would be of help to the committee, on this occasion. But frankly, after you are out of Congress you lose contact with a lot of these matters. I do not have these individuals cases coming to me any more, where I can see into the administration by Blue Cross/Blue Shield, or whatever

carrier is supplying the administrative procedure within the State; I do not have that access now. So I know very little, frankly, about what is happening under the program today.

I can tell you exactly what we intended and you can judge the situation today in light of what we intended to see whether or not our thoughts are being carried out.

But as I told you, I thought I was wasting the time of the committee actually coming because I just have not had access to the information that I would need to pass judgment upon the performance of it today.

I appreciate the opportunity of being here.

The CHAIRMAN. We have had some new members who have come here.

Ms. Ferraro, would you like to start off, make any opening statement?

Ms. FERRARO. In the interest of time, I would like to submit my prepared statement for inclusion at this point in the record.

The CHAIRMAN. Thank you, Ms. Ferraro. Without objection, your statement will appear at this point in the record.

[The prepared statement of Representative Geraldine A. Ferraro follows:]

PREPARED STATEMENT OF REPRESENTATIVE GERALDINE A. FERRARO

Mr. Chairman, I want to thank you and commend you for holding this hearing. Today, we will examine and evaluate fifteen years of Medicare, a program vital to the well-being of our senior citizens.

Fifteen years ago, Congress established Medicare to provide a national health insurance program for the elderly. This innovative and much-needed program to provide quality health care for the aged was based on the premise that health care is not a luxury, it is a right of all Americans. The goals of Medicare were straight forward: to provide protection against costs of in-patient hospital care, care in a nursing facility, and home health care. This is Part A of the program and is paid by Social Security taxes. Part B of the program, a voluntary supplemental protection program, was designed to help pay for doctor's services, out-patient services, and medical supplies and equipment. This voluntary program is paid jointly by the beneficiary and the Federal Government. Together, the two parts of the program are supposed to insure adequate health care for the aged.

Medicare was hailed as a monumental achievement and rightly so. Medicare is necessary and our senior citizens are grateful that it exists. But more and more of our elderly are voicing the opinion that Medicare is no longer meeting their needs.

Health care costs have skyrocketed in the past ten years. As those prices increase, a bigger bite is taken out of the pockets of those least able to afford it. Those participating in the Medicare program are paying more and more in premiums and are getting less and less in benefits.

The amount of mail I receive from the seniors in my District is testimony to the fact that they fear they will no longer be able to afford health care. They fear the rising costs of premiums coupled with the annual deductible will price them right out of the program. They are concerned that Medicare does not provide coverage for such vital services as dental care, eye care, hearing aids, and chiropractic services. Of course, our elderly are expressing concern about the problems they encounter obtaining reimbursement.

These are all very legitimate concerns which we must take into account as we look to see if Medicare is really meeting the needs of our senior citizens. As we examine fifteen years of Medicare, we must reflect on the greatness and necessity of the program as a whole, but we must not be blind to its defects. The Committee's well-documented report has shown that the current Medicare program is not meeting the needs of the aged. Any long-standing program needs to be updated, changed, amended, to reflect and address the problems of today, and Medicare is no exception. I am pleased to be a cosponsor of Chairman Pepper's legislative package for

the elderly, which among other things, calls for the expansion of Medicare coverage, the expansion of home health services, offers incentives to physicians to accept assignment, and reduces fraud within the program. We must now act to improve Medicare so that our promise to our nation's elderly can be kept.

Thank you.

The CHAIRMAN. Thank you very much.

Ms. Bouquard?

STATEMENT OF REPRESENTATIVE MARILYN LLOYD BOUQUARD

Ms. BOUQUARD. Thank you very much.

I would like to welcome Mr. Cohen and my dear, dear friend Mr. Mills to our committee today to share their wisdom in what is certainly a challenge for all of us here as members of this committee.

I want to thank you for the great contributions you have made to the programs that have provided an accessibility to our medical program. It was certainly a privilege for me to serve with you and observe your leadership. I think you are a very great man, not only as a member of Congress but the work you are doing now.

Thank you.

The CHAIRMAN. Thank you.

Mr. Hopkins?

Mr. HOPKINS. Thank you very much.

I simply would like to ask unanimous consent to enter my statement into the record.

The CHAIRMAN. That has already been submitted for the record by the Chair.

Mr. HOPKINS. Thank You.

The CHAIRMAN. Mr. Evans?

Mr. EVANS. I have no opening statement, but I would like to commend you for holding these hearings on this most important issue that we need to be reassessing at this time.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

We will have another opening statement by the other Wilbur in this marvelous pair of Wilburs, ace Wilburs.

Mr. Wilbur Cohen is another legendary figure in this field of legislation. I first came to know Mr. Cohen when he was Under Secretary of HEW, and then he was in the White House. I do not remember whether you were in the White House before you became Under Secretary or not. I know he served as Under Secretary of HEW.

He was on the staff of the Social Security Administration and I believe you were in the White House also as Adviser to the President in this area. Then later on he became the distinguished Secretary of Health, Education, and Welfare and made a great record with his knowledge and vision and drive and comprehension of what services he thought the Government could properly render to the people of this country. He has been a stalwart friend of this legislation that he and Mr. Mills made possible, defending it on all occasions from everybody who would attempt to weaken it or impair its original meaning. And it has always been very heartening to know that when anybody dared to want to impair social

security or SSI or medicaid, they had these two men to scrap with, because they were ready to jump to its defense, to tell the people and the members of Congress what detriment they thought would ensue to the public good if some of those things that were proposed were done.

So we are more than honored to have him here this morning, because he and Mr. Mills have worked together as true friends in a great cause for many years, and we would like to invite an opening statement now by former Secretary of Health, Education, and Welfare, now Prof. Wilbur Cohen.

STATEMENT OF HON. WILBUR COHEN, FORMER SECRETARY, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. COHEN. Thank you, Chairman Pepper, members of the committee, it is indeed a great privilege to come here 15 years later and find that something that you have worked on for 15 years prior to that time too is not only a legislative reality but something which your committee feels needs further improvement and development.

I am reminded in making my presentation today of a very famous story told about Winston Churchill, which I think epitomizes my view today.

As many of the members will recall, during the height of World War II a good many of the temperance ladies of England came to see the Prime Minister at 10 Downing Street and tried to persuade him that during the height of the war he should stop drinking his famous and rather expensive liquor that he imbibed rather extensively. And as they tried to persuade the Prime Minister, one of the ladies said, why Mr. Prime Minister, during your lifetime you have consumed enough liquor to fill this whole room halfway full, and the Prime Minister looked at that room there and then he looked up and he said, "How much I have done but how much more there is yet to do." And I feel somewhat like that today.

I am very proud of the association I have had with Mr. Mills and Mr. Byrnes at the time, because it was a bipartisan effort with the Members of Congress in developing this legislation. But, on the other hand, I feel very strongly that it is a proper time for the committee to consider how to improve it, because there is much more yet to do.

My own philosophy is that all social legislation is a matter of process, is a matter of development. It is necessary in our kind of a democracy to obtain the support of the people not only who pay the taxes but who will receive the benefits. As Chairman Pepper knows, because I have worked with him since the early 1940's when he was a Member of the Senate and a great leader in health care, in the early days—this will be hard I think for some of the younger members and many of my students to realize—that anyone who proposed any of these health plans was immediately attacked as being a Socialist and a Communist.

Part of the reason for the long delay in social legislation is that Members of Congress, as well as members of the executive branch and others who became proponents of any form of this legislation, were castigated, criticized, and I would say that was true not only

of myself but my family, by people who felt that this was a radical, un-American, communistic, foreign institutional invasion of the privacy and the privileges and responsibilities of American citizens.

So ladies and gentlemen, my first point about the great accomplishment of medicare is that it broke the back of the ideological opposition that had been occurring for 55 previous years in American society.

No matter how critical you are of individual elements of medicare and medicaid, as I am, I ask you not to forget the 55 years of struggle by many legislators and many public people who tried to think of various ways to improve the health care system when they were attacked. And I know this is true, and I am sure Chairman Pepper can tell you a lot about the campaign of 1950 in Florida; there were periods of time when I would not dare go to Florida myself, knowing what the doctors at that time thought about me.

But it is a rather remarkable indication of the American ability to change and to develop ideas that medicare is now, I would say, an accepted part of the American system of government, the American system of society. And I would like to tell you that this last year I was invited by none other than the American Medical Association to come and talk to their staff and their physicians, from their State and local societies, about the program.

I went and I feel that there has been a remarkable change of attitude on the part of the physicians of this country who are now willing to consider changes on their merits with no longer the appellation of communism, socialism, or radicalism, which was a major factor in retarding Congress ability to undertake this program.

I also wish to record the great genius that Mr. Mills and Mr. Byrnes exercised at that time in fashioning a program that did aim to neutralize the opposition. So that the second great achievement of medicare was that it was inaugurated with no strikes on the part of the doctors and no difficulties such as some of the socialized medicine schemes may have had.

I may tell you that President Johnson was intensely concerned and he talked with me nearly every day in the last week before we inaugurated the system, about what I was going to do if aged persons were lined up outside of hospitals with physicians refusing to admit them. And while this is little known, and I say this today and probably publicly for the first time, President Johnson as Commander in Chief authorized me as Secretary to utilize any veterans' hospital or armed services hospital if any aged person was not able to get into a hospital on July 1, 1966, when it became effective.

President Johnson, whom I think was a sensitive and instinctive political leader, was intensely afraid that the program was going to start under tremendous political opposition. But I say to you today that genius which Mr. Mills and Mr. Byrnes and other members of the Ways and Means Committee exercised prevented that.

On the other hand, I want to say I give a lot of credit to the physicians. When shortly thereafter I met with the AMA physicians, I made what I thought was a rather important statement to them and I said, "Gentlemen, Congress has passed this law and the President has approved it. You do not have to love a law that

Congress has passed, but you must obey it, whether you love it or not, until either the Supreme Court has ruled it unconstitutional or Congress has amended it or repealed it."

And we were able to obtain, I thought at the time, a reasonable degree of cooperation with the medical profession because, irrespective of what you may think about their individual fees or their relationship, my opinion, as the initial administrator of the program, was that we needed the cooperation of the physicians and the nurses and the hospitals. And I would say this: In those early days they gave that cooperation and I think that set the medicare program on to a successful administrative operation because, Mr. Chairman and members of the committee, there were a great many people at that time who felt that, irrespective of the merits of the system, we couldn't possibly administer it efficiently.

While there are things that have to be changed, and if I were still the administrator there are changes I would make, I would like to say this: that, compared to many of the other mammoth programs and other things that Congress enacted, I think you can be reasonably proud of the efficiency and the economy of this system.

The hospitalization insurance, part A, is administered at a cost of about 2 to 3 percent of total premium payments; part B, somewhere around 7 percent. I am not saying that it is perfect, but I am saying you can take reasonable pride in the fact that, considering the millions of people and provisions, the difficult kinds of questions about paying bills, the points that Congresswoman Oakar made, I still would say before you, it is one of the more efficient and appropriate programs that you can feel proud of.

I would like to subsequently make some suggestions for how to improve it. It is not perfect. But I do feel that the 15-year experience has shown that the Federal Government's administration of that, largely taken under the direction of Mr. Ball and Mr. Hess at the time, has become a model of medical care administration, which I think means that you can improve the program on that base, because there is a solid base.

Now the third important factor that is in the program is the one which I stated right in my first report to the Congress, which I made to you on June 14, 1968, in which I said, and I would repeat now in these 15 years, there has been increased utilization and access on the part of aged persons.

I think there is no doubt, and the annual report submitted to you by the Board of Trustees will bear this out, that older people today get more and better medical care and more access to the delivery system than was the case in the late sixties. So from that standpoint, despite the drop in the proportion of the total medical care costs that are borne by medicare, I would argue that that is so.

May I merely say this: Since I am 67 years old and now one of medicare's users, I have used it several times this year. I have had two small heart attacks this year, and I have been a user of medicare. I am delighted that when the doctors found out who I was, they did not do what I thought they might do because in previous periods I had had several very unfortunate encounters with physicians. And I find them now, in this sense, they no longer say, as they did in the sixties when Mr. Mills and I were working

together, that this program was going to undermine the quality of medical care.

Those of you who were Members of Congress at that time will remember two arguments made against the medicare program. The first was that you would have to stand in line and get a number like you would do at the meat market or grocery store before you could get to see a doctor or into a hospital.

Now that has not happened. That was a common complaint, an attack that Members of Congress heard.

The other one I remember so distinctly, which was every doctor would have to call the Surgeon General in Washington before he could make a diagnosis and treatment. That did not happen either. But I do feel that older people got greater access to medical services.

Now there is one great achievement of medicare which is very seldom mentioned, but I feel that it is a great achievement in medical care. It was one of the most serious problems at the time that we had.

You will recall in 1964 with the passage of the Civil Rights Act, one of the questions was, how are you going to administer the medicare program along with the Civil Rights Act? The result of medicare becoming effective in 1966, most of the signs, "white" and "colored," over medical facilities throughout the South and where it existed in other parts of the country were immediately taken down.

I consider that the application of medicare to the minority group access to high-quality care resulted in not only increased utilization for minority groups but southerners and others who wished to eliminate the discriminatory treatment to use medicare as the reason for it.

And I must say this, I received the utmost cooperation from Southern Senators and Southern Members of Congress in doing that. It is a very little-known aspect of medicare. Nobody wants to really talk about it in the sense that I have talked about it today, but as I look back on those 15 years, and Members who come from the South or border States I think will realize what I am saying. It is that the application of the principle of equal treatment under law of medical care has been developed under both medicare and medicaid and is one of the achievements which I personally say I am most proud of. So that I consider that that is an important achievement.

The other achievement of medicare in my opinion is that it did result in a cooperative effort on the part of the public and private sectors.

We have a long history in this country of competition between the public and the private sector. You needn't tell Members of Congress that in different kinds of programs, whether it is the Postal Service or energy or the gasoline tax or what, we have a wide difference of opinion on how to use the public and private sector.

But under Mr. Mills' and Mr. Byrnes' leadership, and with the cooperation of both President Kennedy and President Johnson and the executive branch, we worked out the most unique, cooperative public-private sector relationship in the history of any program.

And that is, while the revenue is collected through a Federal tax and the Federal Government handles the financing of it, as Mr. Mills said, by using the so-called fiscal intermediaries or the carriers, we were able to gain the support of the physicians and the doctors who, while they were perfectly willing to receive the funds, did not want to be contaminated directly by a Federal check.

So the genius of what I think was worked out cooperatively is the use of Blue Cross/Blue Shield, and the insurance carriers as the mechanism for the payment of the bills which represents, in my opinion, maybe not a pristine power solution from the standpoint of people who either believed that you can—if you are for the public sector, you must be against the private sector; if you are for the private sector, you must be against the public sector.

But in this piece of legislation we have worked out a mechanism in which there is public sector responsibility in appropriate ways that obtains a certain degree of equity throughout the country, respecting the equality of treatment which I believe is so important in our Nation but, at the same time, decentralizing the administrative operations in a way that retains the use of the managerial ability of the private sector, but still, under what is now the Health Care Financing Administration of the Department of Health and Human Services—in my day it was of course the Social Security Administration—aims to result in what I call a balance between these two conflicting ideals, these two conflicting principles. That is not to say that you cannot improve the administration of the program, as I said before.

I think it is proper for the administrators to terminate some of these intermediaries when they show they have not been efficiently organized.

But, considering public opinion in this country, the breadth of this great Nation with 50 States, 3,000 counties and regional and ethnic differences, we have worked out a program that gives you nationwide coverage in medicare on a basis of not 100 percent equality or equity—that is very difficult and almost impossible because of the range of facilities—but gives you that degree of equity with a great deal of decentralization and the use of our managerial ability.

I would hope that whatever changes you make in that program you would keep that fundamental principle because with that fundamental principle I think you can strengthen and expand and improve the program.

Mr. Chairman and members of the committee, in conclusion, a couple of years ago I was appointed by the Speaker of the House as the Democratic member on the National Commission on Social Security.

Under the statute reported out by the Ways and Means Committee, this Commission is to report on January 11 of next year to the Congress on its recommendations for changes in social security and in medicare and medicaid.

We are just in the middle of that discussion. I have just about concluded my recommendations for changes in medicare and should you wish to inquire of me I would be glad to list those that I am supporting in the Commission. But I would say this as well: I hope that when this report is made, which I think will be of

considerable value to the Congress, you will have a basis further for improving the program.

My great problem is this, and I think one of the members talked about it. I think we need a rather substantial improvement in the medicare program but there is no free lunch and anything that is needed to be done costs additional funds.

Mr. Bonker mentioned that. I think our problem is not so difficult to consider what needs to be done but what priority we ought to give in doing certain things. I can conceive that reasonable people can differ on that point. I think the needs of what ought to be done are probably more than the Congress at the present time would be able to persuade taxpayers to contribute. But I would like to make this one suggestion. Chairman Pepper has heard me say this before.

The most important thing is to take social security and medicare out of the unified budget. The big problem we are having today on the reconciliation resolution and why Congress is forcing itself to cut back on social security and unemployment insurance and medicare is because of the grave mistake made years ago to include these trust funds into the unified budget so that every time you can cut Social Security or unemployment insurance or Medicare, you reduce the deficit.

But you can't ask a single person—I ask you to do this; ask a person whether they think social security is involved in the Federal deficit. They say, what has it to do with balancing the budget? That is a separate program to which I pay and contribute.

The net result, ladies and gentlemen, you are not only going to get yourselves in substantive difficulty but political difficulty if you are going to try to balance the budget by cutting back on trust fund programs which people feel they have contributed to as a matter of right to which they are entitled.

I believe that is the most important question before Congress today, and despite what you read about people saying they want a balanced budget and want to cut taxes, when you ask them about social security or medicare, they say, that has nothing to do with balancing the budget.That is something I pay for and I am willing to pay more and I want a better program.

The only way you can break that nexus is to in some way in the reconciliation process or the budget process take these trust fund programs out of the unified budget. I learned this from Mr. Mills.

All during the years that I testified before Mr. Mills' committee he said, I don't want you to come with a program before the committee in which you are trying to affect the budget or fiscal policy through the social security program.

I think that was a wise policy that Mr. Mills developed during the years he was chairman. I think it is the right policy today and I strongly urge you to take these trust fund programs out of the budget.

I do not think from a political standpoint cutting back on entitlement programs to which people pay specific payroll taxes or premiums or contributions is what the American people have in mind when they are talking about balancing the budget.

I think you can't get very far on your programs which I support like H.R. 3990 which I know you, Mr. Chairman, support, which

has, of course, some additional outlays in a year when under the reconciliation process you want a reduction in outlays.

So that any improvement to Medicare runs right into the reconciliation process and you are never going to be able to improve the program even if you wanted to increase the contributions that people would be willing to pay, which I think they are.

So that is the reason I am strong for changes in the medicare program. I think eliminating the trust funds from the unified budget is such an important part.

The CHAIRMAN. May I interrupt while you are on that particular point to invite Mr. Mills to give his comment on that subject.

Mr. MILLS. I agree completely with the statement. I notice occasionally a President, in the interest of cutting back on expenditures, will withhold highway trust funds. That fund has to stay in balance under the law. You cannot spend in any 1 year more than you take in, so it cannot have an effect on the budget to cause an imbalance in the budget.

I agree completely with what Mr. Cohen has said. I would certainly recommend it. I supported it when it was recommended by the so-called Kennedy Commission. But as I look back on it I know I made a mistake.

Mr. COHEN. When you also consider off-budget is the Pension Guaranty Fund, Postal Service and Rural Electrification Trust Account, there are a whole series of things that are not in the unified budget.

If the Postal Service is off and the Rural Electrification and the Pension Guaranty Fund is off, in my opinion certainly the Highway Trust Fund and social security and medicare should be off the budget.

I cannot find a single American citizen of whom I have inquired—including when I mentioned it to Senator Long, he couldn't believe that unemployment insurance was on the unified budget. All of those are State funds in addition.

State unemployment insurance funds of Florida and Texas are in the Federal unified budget. I think that is ridiculous. I urge you to give very serious thought to that.

The CHAIRMAN. I think it would be more desirable to the committee, if you care to do so, to summarize your recommendations for improvement.

Mr. COHEN. That would take me about 5 minutes.

The CHAIRMAN. Go right ahead.

Mr. COHEN. As I said to you first, of course I wholeheartedly support H.R. 3990 which has not only been reported out by the Ways and Means Committee but as I understand, has been reported out by the Interstate and Foreign Commerce Committee although no action so far as I know.

The amendments which are in there are very desirable and some I will mention but some I will not.

My first recommendation is an attempt not only to resolve the question of medicare but I would hope to help Mr. Pickle as chairman of the Social Security Committee on the financing of social security and Members of Congress.

As you know, part B, the physicians services program, 70 percent of that cost is now met out of general revenues. The other 30

percent comes from the roughly $9.60 premium that the individual pays. But 70 percent of that cost is now borne out of general revenues.

My view is you ought to combine part A and part B and pay 70 percent of the total out of that, reduce the payroll costs accordingly and thus be able to divert that money to make the social security system financially sound because by 1981–82 you will be faced with the question of how to finance the increasing costs of social security.

Mr. BONKER. Could you go over that one more time?

Mr. COHEN. Yes. Let me start with part A. As you know, part A, which is the hospitalization that Mr. Mills referred to, is financed 50 percent by the employer payroll tax and 50 percent by the employee payroll tax.

The CHAIRMAN. The hospital part of medicare comes out of social security funds.

Mr. COHEN. It comes out of the social security, that portion marked for social security, for that portion right now there is 1 percent on the employer and 1 percent on the employee. It is a little more. I have to look it up. It is fully financed. That pays for the entire costs except for Federal employees and the uninsured and for military service for which the Government is paying as an employer.

The CHAIRMAN. Excuse me. I should know, but this is a wonderful opportunity to find out. I am not quite clear whether the whole amount needed for part A is levied as a part of what we generally call the social security tax and then the required amount is allocated with the payment of hospital requirements, or whether the special tax is levied to take care of part A.

Mr. MILLS. There is a special tax, but it is included within the overall, so that there is one tax paid by the taxpayer for social security.

The CHAIRMAN. But a part of that is allocated.

Mr. COHEN. Yes. I will now give you the exact figure. Each year under the law the Board of Trustees submits a report not only on the social security disability and survivors insurance but one report on the hospital fund and one on the part B.

These are the two reports which came to Congress recently. They contain a full explanation of the financial basis of the operation, including what is invested in funds.

On page 13, in 1981, 1.05 percent of payroll on $25,900 plus 1.05 percent—of the same amount for the employer—is part of the total social security contribution, which is then allocated by law specifically to the hospital fund.

Mr. BONKER. Is there a separate fund established within the trust fund?

Mr. COHEN. Let me say this, Mr. Bonker. There are four trust funds. You have the Federal Old Age and Survivors Trust Fund. You have the Disability Insurance Trust Fund. That was the one on which we had so much controversy these last couple years. Then you have the Hospital Trust Fund. Then you have the Physicians Service Trust Fund.

There are about $50 billion in total in these four trust funds. You might think that is a lot of money but when the total social

security system is spending $150 billion a year, that is a small amount and they need a cash flow of at least $9 to $10 billion a month just to make the payments.

That is the reason why in the recent bill you passed you reallocated part of the money from the Disability Fund to the Old Age Fund, because there was a little more in the Disability Fund.

Mr. BONKER. Mr. Cohen, of the four funds within the trust fund, only the Physicians Services is statutorily designated. Does that mean the rest of the money from the employee/employer contributions go into the overall fund?

Mr. COHEN. No, sir. Let me go back a little bit.

At the present time the total tax on the employee is 6.13 percent of the total taxable payroll of $25,900. That is the total, 6.13 percent.

Of that amount, by law—not by administrative regulation—by act of Congress, a certain proportion is allocated to the Old Age and Survivors Fund. A certain proportion is allocated to the Disability Fund. A certain proportion is allocated to the Hospital Fund.

The fourth fund is handled completely different. Part B, the way we have worked it out—since it was voluntary, you couldn't have a payroll tax—so what Mr. Mills worked out, was that the individual over 65—and now, of course, the disabled person—pays a premium between $9 and $10 a month and that is a monthly premium which the aged person pays to voluntarily be in part B.

But that only pays 30 percent of the total costs. The other 70 percent is out of general revenue.

Mr. BONKER. I just wanted to know if we make our contributions through payroll deductions that the first three categories are statutorily allocated for those various funds.

Mr. COHEN. You are correct.

Mr. BONKER. We know how much goes into each. You gave us a breakdown. They are in the law.

Ms. OAKAR. May I ask a question at this point?

The CHAIRMAN. Yes.

Ms. OAKAR. I wondered if either of the gentlemen feel medicare should be removed from the social security element as a separate entity in and of itself because a lot of people blame, whether it is true or not, the medicare aspect for the high costs attributed to social security, that we might not have had prior to the sixties?

Mr. COHEN. I think on balance, Congresswoman, I would say no, and let me define my philosophy and Mr. Mills might want to comment.

I think the great genius of the social security program—and you may not always think of this because your constituents are demanding more benefits and less costs. We can all understand that—it sets a kind of political discipline, if you can look at it that way, that if you want more benefits you have to pay more for them.

Of course, if you only look at benefits you are going to get a tremendous support, but if you say, will you pay more taxes for these benefits, you get a slightly different type of answer.

I think, on balance, I would say that it is better to keep some kind of fiscal discipline in the system in which people contribute so

that people have an entitlement by law, or what I call a statutory right without a means test, because to me the greatest thing to fear is in the budget crunch, to add an income and resources test or means test to the benefit.

I think that is what people mean when they say welfare has a stigma. I think in order to keep the system as an insurance program it is wise to have a substantial amount of the payroll contributions of employers and employees finance it.

I think that is what Mr. Mills agreed to at the time. Am I not correct, Mr. Chairman?

Mr. MILLS. That is right.

Ms. OAKAR. Should we merge the four trust funds, then, so we don't have to borrow as we did recently from the disability?

Mr. MILLS. In the bill you just passed you reallocated from the disability to the old-age fund, but I had indicated my willingness to borrow from any of the funds because the two health funds are in a little better shape than the old age fund is. That is only a temporary situation.

You will have to give some reconsideration in 1981 and 1982 to how to deal with the social security system because the costs of that are going up. We just made a 14-percent increase in the benefit and when there is a recession the income is going down and the health payments are going up.

So we all have a problem to deal with.

The CHAIRMAN. If I may, may I suggest to the committee that we first emphasize the improvements Mr. Cohen and Mr. Mills recommend and then we will go into financing of social security and the like.

Please proceed with your recommendations.

Mr. COHEN. My second recommendation is I would eliminate the $60 deductible in part B. I would retain the 20 percent co-insurance. I think that is sound. But the $60 deductible has become a very big bookkeeping problem for physicians and patients. I would recommend its deletion. I think you will find rather widespread support for that for other reasons as well.

Mr. BONKER. May I ask one question on that. I made a cursory review of the committee's recommendations but it seemed to me that with respect to part A the coinsurance provisions be repealed.

Are you suggesting part A or part B?

Mr. COHEN. Part B, the coinsurance is in part B.

Your problem with all of this is how much money you want to put in these different things. If you ask me in a highly theoretical way what I look to do with the coinsurance, my answer would be yes, sir; especially as a medicare beneficiary.

But in terms of social priority, for instance, in H.R. 3990, I would spend more of my money on preventive care. I would include the Paps smear, the influenza injections and some kind of a permission is in there that when you get an examination it will be partially paid for.

I would like to include the hearing aids and the eyeglasses, not 100 percent, but on some kind of coinsurance.

The CHAIRMAN. And home drugs?

Mr. COHEN. Yes; and I would like to have unlimited home care as you recommended.

The CHAIRMAN. Mr. Cohen, I am informed that Mr. Mills has to leave in 15 minutes. May we give Mr. Mills an opportunity to make any comment and then we might want to ask a few questions.

Mr. MILLS. Mr. Chairman, let me just say this: Medicare's great mistake, I think in the beginning, was its perhaps sole objective of taking care of people in hospitals. That is the expensive way, of course, of treating an illness.

Mr. Cohen has suggested more emphasis should be placed upon outpatient care. I would certainly agree with that recommendation.

We were only interested in the beginning in the person who was sick who had to be hospitalized. That is what we took care of. But it is so expensive. We have learned that over these 15 years. Now if we can redirect the program in some way to prehospital ambulatory-type care, prevention, I think it would make a tremendous difference in the costs of it. This would be my primary recommendation.

The CHAIRMAN. I have been told in view of our present tight budget situation it is unlikely we can get into that stage where we authorize new services that cost money. However, one of the recommendations in Chairman Charles Rangel's Subcommittee of Ways and Means, which has been approved by that committee and also by Interstate and Foreign Commerce, is to authorize medicare to pay up to 95 percent of the costs that it ordinarily expends in the care of a part A patient, in care of a patient by an HMO organization.

This is to encourage comprehensive care.

I have been toying with the idea: What if Congress authorized the medicare administration in any case where they could give some other kind of care—home care or some other kind of care—and stay within what it would otherwise cost normally to take care of a patient on an average, to give them that permission.

That would give them an opportunity for experimentation using HMO's, home care and the like, but the limit would be you must not go beyond what you would spend on the average if you used the normal method.

What would be your comment on that?

Mr. MILLS. I think it is a good idea. Actually, I think you will find that any time you can pay more of the costs of outpatient care, your overall costs will be less.

I like the sharing of the costs after a certain time by the patient. But so far as preventive care, the fewer deductibles you have, the greater the cost in the short run by the Government. I think we are better off in the long run since we incur less cost through prevention.

The CHAIRMAN. One other question, Mr. Mills, and I will give my colleagues an opportunity. Way back in the early days of 1936, while I was running for the Senate, one of my friends who had been defeated supported the Townsend plan and came to me and said, if you don't support the Townsend plan you are not going to get elected.

I gave some consideration to it and finally I found out the idea was basically all right, maybe the detail might be open to question.

The years passed. I am on the Rules Committee and Mr. Ullman, the Chairman of the Ways and Means Committee, came before us

recently and said maybe in the future we are going to have to give consideration to financing part of the social security by some sort of sales tax or something like that.

My question is: Do you foresee in the immediate future any likely change in the base of the social security funds?

Mr. MILLS. In the financing of it? Yes, I do. I have thought for some time, even before I left Congress, it is unfair for people to pay the costs of somebody else's care or somebody else's retirement. This is what is taking place now under the payroll tax. About a third of the total costs that are attributable to the old age and survivors program are based upon some aspect of welfare.

We have a minimum payment which disregards the true payment that the individual would receive if you look only at wage that is taxed.

We have the benefits in the lower level much higher than they would be if you were truly reflecting the relationship of the upper beneficiaries.

A third of the total costs are welfare related. Organized labor says that a third, therefore, percentagewise of the costs, should come from the general fund.

I would not go on the basis of a percentage because if you adopt it at one-third, sometime Congress will say, one-half should be paid out of the general fund because we think the people are entitled to higher benefits; later on maybe three-fourths. But there is a way to estimate the actual cost that is welfare related.

The general funds should pay that not on a percentage basis, you understand, but actually on a dollar estimate cost and then an adjustment could be made at the end of the fiscal year.

I would certainly recommend that, rather than to provide credits for social security against income tax or to say that a percent should be established.

Let's try to look at it on the basis of the facts, come up with an answer addressed to the facts.

If I am paying under social security my costs and a third more to take care of somebody else's benefit, that is not fair to me as an individual.

Why shouldn't that be done out of the general fund since it is welfare in nature? So if we look to the dollar costs and address ourselves to that dollar costs out of general funds, you are not then trapping yourself in a position where percentagewise you can increase the percent just because you want to increase the benefit.

You still have a relationship to benefit and wage earned. I think you have to maintain that.

The CHAIRMAN. Thank you.

I want my colleagues to have an opportunity to ask questions. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. I am not going to take the time to ask any questions but I want to again thank Mr. Mills for being here this morning. You know after 38 years in the Congress he is the busiest retired man I know. He goes all over this country speaking on alcoholism and being very busy. I appreciate that. We can sit here all day and ask him questions and get good answers, but I am not going to take his time or the time of my colleagues.

The CHAIRMAN. Mr. Bonker.

Mr. BONKER. You are a great resource. I wish we could tap it more often. Maybe we can have an informal session at some point. You made an interesting statement when you said that one-third of the funds in the social security trust fund are welfare related.

Mr. MILLS. One-third of the costs.

Mr. BONKER. One-third of the costs. You said general revenue should help finance that?

Mr. MILLS. Yes.

Mr. BONKER. But Mr. Cohen said earlier that we ought to take the trust fund out of the general budget.

Mr. MILLS. You can do that. There is no conflict at all.

Mr. BONKER. Wouldn't it be easier assuming that most of that welfare-related money is in the disability portion——

Mr. MILLS. No; it isn't. That is in the retirement part that I am talking about. Entirely in the retirement part. There is some in disability but it is a smaller amount. Whatever it is in both of them should be paid out of the general fund—dollars, not percentage.

Mr. BONKER. Are you suggesting the general fund should supplement the social security system?

Mr. MILLS. That is what I am saying. You can do it on the basis of an estimate at the beginning of the year, however you want to do it, but at the end of the year you have an actual figure. If you overpay, the fund would pay back to the general fund. If you underpay, the general fund would make up the difference. It could be done.

Mr. BONKER. The recommendations that are in this report, some of which you have touched upon here today are that we ought to expand the present medicare program in various respects and for outpatient treatment for home health care. I think we ought to reduce some of the cost burdens still in part B.

But that is going to involve more financing. We have already increased both the tax base and the tax rate and they will be progressively increased now or indexed over a period of time.

If we are going to take your suggestion and supplement the trust fund through general revenue, is it not possible that we could then expand the medicare provisions for more expansive coverage and finance that out of the general revenue that will come in to supplement the fund?

The question I am getting to, there is a suggestion made in this report that we ought to find other sources of revenue to help pay for expanded medicare coverage, excise tax on tobacco and other things.

I would like to know your response to that whether we should stick with traditional sources of funding or try to tap a variety of revenue sources that come in other ways.

Mr. MILLS. I have always believed that we should pay some way through payroll tax for these future benefits. I hesitate to think that it turns on some other unrelated tax. We may in time have to do it because we may not be able to come up with any other solution, but whenever you do that you are losing in part the relationship between the tax paid for a benefit and the benefit itself.

The CHAIRMAN. Mr. Hopkins.

Mr. HOPKINS. Thank you, Mr. Chairman.

Mr. Mills, I am no expert on the social security or medicare, but I am the world's greatest expert on what I think. I would say to you that in my view the people are concerned about two things. From my perspective, they don't mind paying into social security but their great concern, and justifiably so, is that it may not be there when they arrive.

In medicare I think one of the concerns they have has to do with fraud and abuse. We have concerned ourselves most of the morning talking about the costs.

Let me ask you your opinion on the other, savings, side of the coin. It was revealed by then Secretary of HEW Califano some $2.2 billion was misspent through fraud and abuse.

What do you recommend that the executive branch and perhaps the Congress do to address that problem so that we don't contribute more to fraud and abuse but in fact cut it down so that we don't have to continue looking for ways to supply the new revenues to programs which we must have?

Mr. MILLS. In the first place, I have no way of knowing whether that figure is accurate or not. To me it would be on the high side, I would think. I can't conceive of any agency of Government administering any program to allow that much fraud to go unaddressed by the agency. If it is, it is an agency responsibility.

You can't administer the law from where you sit. It is entirely up to the executive agency that does administer it. If they need help, it is up to them to come to the Congress and ask the Congress for such additional legislation that will better enable them to administer the law.

It is an individual case. You look at each case and perhaps there is something Congress can do but I have no idea what it can do.

Mr. HOPKINS. HEW has said, as a matter of fact, that was a conservative figure.

Mr. MILLS. It may be the figure but I don't think it is. I can't conceive of that much fraud. But if it is, it is high time the agency asked the Congress for some legislation, if legislation is needed. I don't know what the legislation would be.

Mr. HOPKINS. Thank you very much.

The CHAIRMAN. Thank you, Mr. Hopkins. Ms. Oakar.

Ms. OAKAR. Thank you, Mr. Chairman.

I would like to ask Mr. Mills why do you assume, since both of you said one of your priorities would be home health care, that is going to cost more? If you eliminated hospital stays, which in terms of certain statistics I have looked at, are much more expensive than doable health care services at home, you would be saving money with respect to certain areas of the trust fund and eliminating some of the notions like that you have to have high blood pressure to get a free blood pressure check as opposed to encouraging older people to deal with possible hypertension and avoid catastrophic illness.

In your experience as chairman of the Ways and Means Committee, did you ever do costing related to home health care versus other?

Mr. MILLS. No; we made no study at all. We just called on the Department.

Mr. COHEN. We did. At that time it was very unknown but in answer to the Congresswoman, I would say that you have two problems. One, there are 100 home care visits limit in part A and 100 in part B. I would prefer to have them all in part B if I could, but have them unlimited.

Now you can only get 200 out of 365 and in part A you have to have been a hospitalized person before. I would do away with that requirement. I would give the person home health services irrespective as in part B whether they were in a hospital or not.

It does cost a little more for the home health service but I would agree with you in the long run it would reduce the costs of hospitalization.

Ms. OAKAR. Because many people say I have to go in a hospital to in effect get the home health care services that I need.

Mr. MILLS. That is right.

Ms. OAKAR. If you cost it out in terms of the duration in the hospital versus the need they might have temporarily if they get ambulatory for a certain period of time, by and large, on occasion you find that it costs less.

Mr. MILLS. The whole of Mr. Cohen's statement I think is that we are trying to prevent the necessity of a person having to go to a hospital. If we do that, certainly the costs will be less.

Mr. COHEN. Secretary Califano has been hired as a lobbyist for the home health care industry so I would assume in the course of time we would have more home health care services both on its merits and because we have another ally.

Ms. FERRARO. I don't have a question, Mr. Chairman. I just want to thank you, Mr. Mills. I was not aware when I was elected that I was going to receive such an education and I appreciate your testimony.

The CHAIRMAN. Thank you very much, Mr. Mills. We are very honored to have you and grateful to you for coming.

Ms. FERRARO. I do have one question of Mr. Cohen. I do have to leave.

Your first recommendation, I did not understand. When Ms. Oakar questioned whether or not you would take all the money for that particular trust fund out of general revenues you said no.

Mr. COHEN. I would take 70 percent out.

Ms. FERRARO. Where would the other 30 percent come from, from contributions?

Mr. COHEN. The other 30 percent comes from the payroll tax.

In part A roughly the employer pays 1 percent and the employee pays 1 percent. In part B you have the premium of $9 some cents plus 70 percent coming from general revenue.

I would consolidate A and B, cover everybody in the United States under both A and B, and then I would pay the 70 percent of the total costs of that out of general revenues, thus reducing the payroll costs somewhat and allocating that payroll as against the part A, putting it in the social security system directly so you wouldn't have to increase the payroll tax in 1981 or whenever it was affected. It is doing about three things at the same time.

I recognize paying 70 percent of part A would increase the amount on the general revenue and that would be a very serious problem. Maybe you would have to do it over a 5-year period, 10

percent, 20 percent, 50, 60, et cetera. As the chairman says, you have a financial problem.

But I want to say this to you, because you will be here in 1981, 1982, and 1983, you are going to have two problems together. At some time you are going to have to figure out how are you going to keep social security financed and sound.

Are you going to raise the payroll tax for social security? With the cost of living added onto social security, 14.3 percent this year because of the recession, we are in a tough situation.

So what I was trying to do was to help you meet the social security costs but at the same time combining part A and B and putting in some general revenue.

I think that is very politically difficult to do in the 1981 budget. But what I am trying to suggest—I didn't say this—I would like to see you pass a bill that made this effective now in fiscal year 1982 and thus preempt some of the income you are concerned about in this medicare field.

The way I see it now from long examination in the 1980–81 budget, unless you begin to put your demand in for the 1982 budget, by the time it comes along, somebody has already used up all the money. Congress has to really decide nowadays about 2 fiscal years ahead if that is what their priority is.

You may have to have some kind of working out with the Agriculture Committee or somebody else as to what they think is priority. If you wait for the fiscal year that you want to make it effective, I am convinced that is too late.

Ms. FERRARO. Thank you, Mr. Chairman. Thank you, Mr. Cohen.

The CHAIRMAN. Mr. Cohen, we were all very much concerned about increasing the access of the elderly to home care. Would it require an amendment to the medicare legislation or can more care be provided administratively by medicare authorities?

Mr. COHEN. The answer to those is yes to both questions. Home care has had a difficult time in 15 years because it does not exist in its full-blown adequacy that I would like to see it in the United States in every community.

I think we have made great progress, but I don't think you could go in every community and get all the home health care that you want.

Second, I believe that the provision that is in the law in part A, making that particularly contingent on the 3-day prior hospital requirement—to eliminate that in 1981 it would probably cost about $16 million more, they say.

The CHAIRMAN. If I recall correctly, one was to eliminate that requirement before you could get home care, the other was to eliminate the deductible that you have to pay to get home care, another is to eliminate the 100-day limitation on visits and the other is to permit medicare to pay and experiment, as it were, for HMO care for an individual up to 95 percent of the average per covered person.

Mr. COHEN. I would not only favor all of those, Chairman Pepper, but if you couldn't get everything through in H.R. 3990, I would prefer for you to take all of those out as a separate legislative vehicle for this reason.

The other things that you have in the bill are all good and they cost money. But home health care is not going to be enacted out of the head of Zeus tomorrow morning just because you pass a law.

This involves community organization to get home health services into your home and to organize the nurses and the community response takes time.

I think the combination of your home health recommendations are not only sound in principle but you should assume that it will take a reasonable period of time for communities to work that out.

I think it is a long range proposition, it is on the right track and I would recommend it as a specific vehicle.

The CHAIRMAN. You mentioned the deductibles. Would you comment on what reduction might be desirable with respect to the deductibles under A and B of medicare?

Mr. COHEN. Let me say this——

The CHAIRMAN. For example, in part A, the deductible is $180 before you are covered in the hospital.

Mr. COHEN. Yes, sir.

You see, I happen to belong to a group health association in which they pay if I have the service in Washington, as I did when I had one heart attack, they paid for that $180 but when I had my services out at the University of Michigan, Blue Cross had to pay that $180 for the first day.

I do not happen to believe that is of the highest priority. I believe it is socially desirable. If you ask me would I like to eliminate, I would say yes. I have eliminated it for myself, but I would rather spend the money on prescription drugs and home health services and the preventive care if you are going to say you can't do both.

You see what my problem is? It is your problem, too, when you take the bill to the House floor, how much are you willing to put some extra costs on.

I would argue that you will make more headway in the long run if you put the preventive and home health and the prescription drug item in because I think people accept that, understand it, and I think it would have merit with the medical profession. I think it is very constructive.

The CHAIRMAN. In part B, one of the problems of the elderly in my view, is a lot are poor and don't have any income except social security. If they get a doctor's services under part B eventually the doctor sends a bill. Very few doctors take assignment. We try to encourage doctors to take assignment.

We can develop incentives that would encourage them. We are going to have a hearing in Miami on that subject: is there too much delay in the payment of claims to the doctors.

The doctor submits his bill. The individual covered has to pay the bill and then he returns his claim for part B to the Government and it takes maybe months before the payment is made, and then the Government decides how much is a proper charge and the doctor may charge $200 and the Government may find he should not have charged but $100. The patient still had to pay $200.

Mr. COHEN. I don't know that I have a perfect solution to this because it is a very complex problem which is not only because of the financial side but this is a philosophical problem on the part of the doctor's mentality. Some physicians, irrespective of the amount

that they get paid, would prefer to be paid by the patient because that is their conception of the doctor-patient relationship.

I don't happen, as a nonphysician, to agree with that, but I have to admit that there are physicians in this country who believe very strongly—and it is a very emotional philosophical argument—that the best doctor-patient relationship is to have the patient pay the bill.

What I would do—and I don't know this will work but I would like to see in the law as many trials—if Florida wanted to do it, I would try it—I would put in a provision that the Secretary, after consultation with the physicians of any community, could establish a fee schedule in that community in which the doctors, if they took assignment, would accept that fee for as full payment and, therefore, not charge the patient any more except for the 20 percent, of course, but they would not in a sense charge more than that.

The CHAIRMAN. Would that be possible under present law?

Mr. COHEN. No, sir. I think you would have to amend the law. I do not think that the concept of the reasonable and customary charge under the present law—you might say, yes, but you have sort of a legislative history that fee schedules were not to be used.

I think you will find in the United States in some communities that they would accept the fee schedule. I think your committee ought to work with the medical profession, I think you would find they would be willing to support an amendment, properly drawn, that after consultation in a community the Secretary could propose a fee schedule for which if assignment were to be used by the physician.

The other alternative is, as you say, the incentive approach. There is another way to do it. Two ways have been suggested. One is that if a physician takes assignment in addition to his payment, he would get an extra dollar or two on an assignment case because obviously he is accepting that and there is the cash flow problem which you talked about.

The other way which I have thought about many times, is if a physician were to accept assignment to give him a $100,000 medical malpractice policy under the part B. It may well be that the Federal Government, by its broad coverage, could have a medical malpractice coverage which it would give the physicians who sometimes find great difficulty in obtaining this. But I would only give it if you accepted assignment.

I am following up your idea of the carrot approach, trying to find some way to encourage assignment either through the fee schedule, medical malpractice to be added to the payment.

The CHAIRMAN. We have two other panels. We have kept you overtime. Is there anything you would like to say in conclusion as to your recommendations?

Mr. COHEN. I think the problem that I stated before is, as you know, from our past association, I would like to see a medicare program that eventually covered practically all of the medical care costs of older people and the disabled—and the disabled which we have not touched upon.

I would go much farther than a disability bill to cover the disabled under medicare because I think they are a very vulnerable group.

The CHAIRMAN. May I ask your opinion on one thing. In Miami, as a consequence of the Latins that live there from Cuba, we have a lot of clinics where the people pay so many dollars a month for medical care and they are supposed to get complete medical care. But they have to pay the deductibles.

One of the clinic operators has come up with the idea of charging the people who belong to its clinic $15 a month and if they pay that $15 a month in addition to the regular amount they pay, they will be given comprehensive coverage and they won't have to pay any deductible if they go to the hospital.

Usually the clinics own a hospital or have a contract with a hospital. So they would provide for that extra $15 the elimination of deductibles and provide comprehensive care. So that amount would give them medical coverage that would be prepaid.

Our Florida Insurance Commission approved that plan and I also received the approval of HEW. I don't know how it will work out eventually but at least on an experimental basis it has been approved.

Have you any comment as to whether that is one of the approaches we should make?

Mr. COHEN. Yes. Let me say this: I not only approve your idea of developing some kind of part C which would be another package, including maybe prescription drugs and a number of other things, but if you asked me what I would prefer—and I say this because I know you and your committee have been strong sponsors of the medicare legislation that you have a part C that really covered everything that was in medigap because despite the standard-setting function that you helped develop in the present law that was passed, I am extremely pessimistic, as I think you yourself expressed on the floor, that would really reduce costs and give universal coverage.

I am insured voluntarily for items not covered by medicare, but I have done that because Congress has not given me any other alternative. I would rather see part C in which a person could get almost complete coverage of major items that we are talking about and I would even go so far as to make it financed on the same principles that part B is to get it started.

I think it is much more important that older people have the opportunity for the protection than that we take another 15 years and argue about the exact method of financing it, because somebody has to pay some of the costs and I would rather see older people have the health protection because people are living longer, there is more chronic illness. When you give people a choice and they make a mistake, then you and I have to pay for it under medicaid anyway. So I would prefer a very broad part C, or expanding part B. That would cover all of what you would call the essentials, including major or life-sustaining prescription drugs.

The CHAIRMAN. Thank you, Mr. Cohen. We could keep you a week. We are most grateful for your being with us this morning.

Mr. COHEN. Thank you.

The CHAIRMAN. Now we have another panel of two, first is Dr. Victor Kassel of Salt Lake City and Dr. Michael B. Miller, White Plains, N.Y.

Dr. Kassel is in private practice in Salt Lake City, Utah, in the practice of geriatrics since 1951. His formal training was internal medicine; informally, psychiatry. His experience has been in social service to the community. He served as a delegate to both the 1961 and 1971 White House Conferences on Aging.

Dr. Michael Miller is currently assistant professor of medicine at New York Medical College in Valhalla. He also serves as medical director for two skilled nursing facilities in White Plains, N.Y. He has served as assistant clinical professor of rehabilitation medicine at both the Albert Einstein College of Medicine and the New York University Medical School. He was a founder and chief of the Department of Physical Medicine and Rehabilitation at Beth Israel Hospital.

We commend both of you gentlemen for your distinguished service to the elderly of our country and are very pleased to have you here today.

Dr. Kassell, we will start with you.

STATEMENT OF DR. VICTOR KASSEL, SALT LAKE CITY, UTAH

Dr. KASSEL. It is a pleasure being here, at least for a private practicing geriatrician. I have had very little to do with Washington since the early seventies, when I was adviser to the Administration on Aging.

There isn't too much that I am going to be able to cover today, but I would offer to your staff some of the writings that I have done. They will emphasize very specifically many of the concepts that a private practicing geriatrician has in caring for the aged.

The CHAIRMAN. We would be pleased to have them.

Dr. KASSEL. Also, one of the major personal advantages of being a senior citizen: No longer does public opinion bother me, so that I can speak freely. The point I want to make is that medicare seems to have been a program developed to penalize the geriatrician in private practice; to discourage any individual from going into the private practice of geriatrics and carry on the care of the aged, in contrast to other specialties of medical care.

I must conclude, that this penalization which was evolved must have been planned in some way, because it could not have happened so effectively purely by accident. As a result of all of this misplanning, the particular recipient of the service, the aged citizen has not received the care to which they are entitled to.

Now, this problem has developed as the result of five points, and anyone who wants to work out a resolution of the inadequacies of medicare, has to consider these five points.

No. 1. We never have had defined quality geriatric care. What is quality geriatric care for the aged? The medical schools up until very recently have not taught the care of the aged. The doctors, whether they are family practitioners, whether they are internists or whether they are psychiatrists, don't know! It is only those of us, who have sort of sloughed through during the past 30 years, who have evolved finally a philosophy of adequate care. It still is not taught adequately at medical school. One sees, over and over and over again, when elderly patients come to you, the inadequacy of the care.

So that in some way, the concept of quality care must be given to the community.

No. 2. The rules and regulations that were developed by medicare were not developed in cooperation with private practicing physicians who are geriatricians. The individuals, who developed these rules and regulations, were M.D.'s who were either bureaucrats or from academia. None of them are in practice, and they do not have the vaguest idea of what is entailed in patient care. So that you have all of the inadequacies that were listed by the previous two speakers, because nobody with practical knowledge was involved in effecting a quality program.

No. 3. As a result of the lack of knowledge about the quality of care, and the lack of involvement of private practicing geriatricians, you evolved an incompetent bureaucracy. Particularly so in medicare part B, where you have hired personnel, who have not the vaguest idea of quality geriatric care.

I remember in Salt Lake City, when medicare came into effect, the individual in charge had just graduated from the University of Utah with a bachelor's degree in biology. He was the person who was selected to administer the program. He admitted to me his ignorance of health care.

No. 4. The development of the assignment concept adds to the disadvantage of the physician. Following his acceptance of the assignment, he can no longer afford to stay in practice. Early in the medicare program there was a private clinic in Los Angeles whose doctors followed the assignment method and in 2 years they went bankrupt.

No. 5. The total fee schedule is inadequate. Much of the concept of medicare and medical care came out of the Blue Cross/Blue Shield experience. Blue Cross originally started as a paying program for surgical patients. To this day, we penalize the nonsurgical physician and penalize to the advantage of the surgical physician.

For example, you will pay a geriatrician $15 to spend an hour with a patient; you will pay an ophthalmologist $1,000 in the same hour to extract a cataract. Who says that the competency, the capability, the level of training that you get in the 1 hour from the ophthalmologist is any more superior or any more entitled to greater payment than the geriatrician?

I must emphasize the following. When it comes to the practice of medicine, and remember, all of these programs are developed primarily for the practicing physician to render service to the patient; without the private practicing physician rendering the service to the patient, the whole thing doesn't mean a thing. And in the hierarchy of medical practice: "Those who can, do; those who can't, teach; and the least fit, administrate!" As long as we appreciate this, and recognize this, then we will come to understand many of the developed inadequacies. There are many examples that I can give of the five factors.

Over and over again, I have found cooperation with the bureaucracy I have found impossible. For example, you asked why doesn't a doctor take the assignments? I did take the assignment until one day, unfortunately, I chose to take care of an elderly gentleman in Salt Lake City whom no other doctor would see. He was an old paranoid man. Suddenly, medicare part B stopped paying me.

Why? Because the patient brought a complaint against me within his paranoid ideation. When I wrote to Denver to find out what the problem was, they wrote back to me and said it would be 6 months before they would open up my account. They were not allowed to discuss it with you. So for 6 months I received no fees because I selected to take care of a man who was psychotic. And the administration was not able to make this psychotic evaluation.

We have the problem in assignment, because if you have ever examined the upper portion of a check, it is impossible to figure out what they are paying for and what they are not paying for. So you have to end up hiring an accountant to go through every check to determine what the payment is. This I do not want to be bothered with any longer. I am there to practice medicine, I am not there to unravel the Government's paperwork.

I also have the problem in assignment in that the patients don't understand the procedure. So I have to hire another clerk to do this paperwork. Over and over again, we become involved laborously with the assignment. We become involved with the assignment because the people down at the fiscal agency do not understand what we are trying to do for the patient.

Another example: I will see a patient briefly for the first time to decide whether I can do anything for the patient, or whether the patient is shopping for another diagnosis, or whether the patient is dissatisfied with his or her previous service. I will spend time talking with the patient, and then make an appointment for he or she to return. The second appointment after that is an hour and a half, during which I do a complete history and a complete physical examination. They tell me in medicare part B that there is no way that they can pay for an hour and a half physical examination.

When you consider that the doctors who are accepting assignments are squeezing their patients in between other patients, they personally are not seeing their patients; their nurses are doing the examination and the doctor is collecting the fee; this is not quality geriatric care.

The CHAIRMAN. Excuse me. I have had some experience in the last few months where there are some doctors working out of one of the hospitals in the Miami area and I found out after we got into it that there was a disagreement, there wasn't a complete understanding between the doctors as to the filing of their claims and the receipt and payment of the claims by the participating agencies. And then we made it clear to the doctors exactly how the paying agency wanted the claims filed. We sped up the disposition of the claims a great deal.

Those are cases where the doctors were taking assignments. I wanted to preserve that practice of assignment. So we worked out an arrangement whereby the paying people went back over all these bills and pointed out why they were tardy in making the payment, pointing out that the doctor did not lay a proper predicate in his claim for the payment of the fee that he asked to receive.

When we told them what the paying agency wanted in there, why then they got along all right. So could we——

Dr. KASSEL. The problem is not in the delay in payment. The delay I can understand. But when you have a system of reimburs-

ing the physician on the basis of the cost of a physical examination, and when you will accept the condition, that a physical examination on a 20-year-old is entitled to the same reimbursement as a 70-year-old, and the reimbursement is on the 20-year-old level, then you are in trouble. If you are going to spend time with a geriatric patient, and this is the major problem, they want time, it becomes expensive.

Consider for a moment how long it takes the aged patient to get into the examining room, to get undressed, to get up on the table, get off the table, get dressed, to extract the information from the patient, to spend the time reassuring the patient. We are talking about an office visit of a half-hour, in contrast to an office visit with a 25-year-old that may only be five minutes.

The thing that medicare has never really considered is the time factor in the care of these patients. If you are willing to pay $6 to $8 on an hour-and-a-half house call, the doctor can't afford to make the 1½-hour house call. You will pay more for an office visit than you will pay for a home visit.

All of this is the result of the lack of knowledge on the part of the administrators of the program, who are not advised by physicians who actually practice geriatrics. You are getting advice from academia. You are getting the bureaucratic physician. These people don't know. So those of us who are out in the field, trying to do the work, are not only involved with a patient who has multiple problems, but we are involved with the bureaucracy which is constantly downgrading us.

I am very much concerned about the fact that the information around is that the physician who accepts the assignment, the medicare physician, is a cheat. So I tell my patients, I am not going to accept the assignment. You know what my service is. You will pay me for the service. You send the bill to the Federal Government so that nobody can say I added to the bill services that were not performed. It is this attitude of physician dishonesty, of physicians trying to take advantage of the situation, ripping off the patient, that discourages me further.

The CHAIRMAN. Do you find there are a lot of people of limited means who find it difficult to pay your ordinary fees for services rendered to them, and wait several months for getting reimbursement and then not getting reimbursement for 80 percent of the amount of your bill?

Dr. KASSEL. It is a very serious problem, and I understand this. On the other hand, how can I continue in practice if I don't get paid? Or if I have to ask my other private patients to subsidize the assignment patient? Or else what I have to do is limit the number of aged patients I see. If you do that, then you throw the whole practice of geriatrics out. There are many physicians who take assignments, but you will find they are able to pay for their office expense because they charge the other patients more.

The CHAIRMAN. Isn't there some way that the medical profession could provide standards by which it would be possible for doctors to take assignments and still get fair remuneration for their services?

Dr. KASSEL. It is not the medical profession who makes the decisions.

The CHAIRMAN. I know, but it sets up standards that—the kind of standards that the Government could follow; could they do that? I am hesitant to assume that the Government does not want to pay or see paid the fair fees for the services needed which are rendered by the physician to a patient.

Dr. KASSEL. I would agree.

The CHAIRMAN. I think that the Government's problem apparently arises with some doctors who are willing to make excess charges, excessive charges, just like some people in other professions, file fraudulent claims and the like. But all the Government, I assume, is interested in is that the patient get the needed treatment and that the doctor be paid a fair fee for the rendition of that service.

It would seem to me there ought to be some way in this great republic of ours by which the Government of the country, which is the Government of the people, and the rendering physician, the services rendering physician could agree.

Dr. KASSEL. I would fully agree.

The CHAIRMAN. So that the individual elderly person, suppose I am getting $150 a month social security and I have an illness and I go to you as a doctor. You will perform your service and you will render a bill, but a person with an income like that doesn't have much money left over for living expenses. Yet in order to get your services he may have to sacrifice essentials of life. Then he has to be out his money for the 3, 4, 5, sometimes 6 months that it takes the Government to pay the claim.

We are trying to get them to pay earlier, but it is such a burden upon so many people to have to pay and then not know how much is going to be paid back, not get it for 4 or 5 months, and then oftentimes not get 80 percent of the amount he paid; he may not get but 50 percent or 40 percent.

Dr. KASSEL. The point you make is a valid one. The way I do it in my own office, patients in those circumstances, I accept the assignment and don't even bill them the 20 percent. Incidentally, if I don't do the billing for the 20 percent, I am liable for criticism from medicare, and I am willing to face up to the criticism. Medicare insists I should bill them for the 20 percent, It is not right legally just to accept the assignment.

The CHAIRMAN. I agree with you on that, in the case of hospitalization, if the hospital wants to accept 80 percent of the bill for its services, the Government ought to permit it; the same way with the doctors.

Dr. KASSEL. Consider the children. there are many elderly individuals who have children. I feel that a cause of the downfall of the aged is the way the country has evolved socially. Children are not assuming responsibility for their parents and for their grandparents. Families must again begin to assume part of that responsibility. But, on the other hand, if they can't afford it, the parents are not denied services. Still one cannot carry on a geriatric practice without getting adequate income to support the practice.

The CHAIRMAN. There is no doubt but that the doctor is entitled to a fair fee for the services rendered. I am just simply saying that maybe if I were administering it I would try to get an advisory group of responsible, competent doctors and they would be my

primary advisers as to what was a fair fee for the doctor to charge. I assume they don't get a lot of cattlemen or citrus growers to decide what is a fair fee for the doctor performing an operation or rendering a medical service. They surely must have advisers who are medical people who advise the Government as to what is a fair fee.

Dr. KASSEL. Well, if you will look at the list of advisers to medicare, you will find that there are no private practicing geriatricians who are advisers. This is one of the major problems. Rather, you have people who don't know, who are determining the fees the services, et cetera. You cannot equate all sorts of services as equal omitting the basis of time.

I would agree with you the Government is interested in that.

The CHAIRMAN. Would it get to the point, I want to tell the staff, when we have our hearing either in Miami or here, we might want to inquire of the Government as to who their advisers are and determine that.

I am surprised if what you say is correct.

Dr. KASSEL. Look at the yellow pages in the Washington telephone directory and see how many geriatricians are listed. There is one man. One man who specializes in the care of the aged, listed in the directory in Washington, D.C. Go through the country. Whatever city, open up the yellow pages, you will never find these individuals. If you look at the group of individuals heading the American Geriatric Society, they are not practicing geriatricians.

I heard a former president of the American Geriatric Society say that it is not essential to make house calls on elderly individuals. When I inquired as to his field, this man said he was a gastroenterologist. He knew nothing about geriatrics. This has been a method for many physicians to develop status and prestige, but who do not want the involvement of the work in actually practicing geriatrics.

I will say again. When the Government advisers are trying to work out a program, they had better go to the people who are doing the work and find out the problems. I listened to the experts sitting here earlier, who are not getting up at 2 o'clock in the morning and going out and seeing a sick 90-year-old. You don't have these same individuals in the community trying to get community service, to get homemaker service in, trying to get decent transportation, decent diets at home; none of these individuals are on the phone trying to effect a solution. All they are doing is administering and developing programs; talking a poor game.

We, down in the grassroots, who are trying to work out the specific inadequacies find ourselves completely frustrated.

The CHAIRMAN. Doctor, you have given us a very able statement. You have given us some good suggestions to follow.

We will take a 5-minute recess, Doctor, and we will be right back for you.

[Recess.]

The CHAIRMAN. The committee will come to order.

Dr. Miller, we are very grateful to you for your patience and kindness in remaining with us. Now, will you go right ahead. We welcome your statement.

STATEMENT OF DR. MICHAEL B. MILLER, WHITE PLAINS, N.Y.

Dr. MILLER. Thank you so much for inviting me here. This has been a very exciting morning for me to see real pioneers in a major social engineering effort, namely, Mr. Mills and Mr. Cohen. I accept the fact they are great men.

It also proves great men can make mistakes. I believe great men make fewer mistakes than the rest of us.

I present a written statement. I won't read from that.

[The prepared statement of Dr. Miller follows:]

PREPARED STATEMENT OF MICHAEL B. MILLER, M.D., FACP, WHITE PLAINS, N.Y.

It is appropriate and timely to assess the effectiveness of the Federally mandated Medicare-Medicaid Title 18–19 programs for the ill aged—their contributions and deficiencies.

The intent of Congress was to relieve the ill aged and their respective families of the astronomical cost of catastrophic illness in the late life span. Medicare (Title 18) had no preceding government involvement in hospital based medical experiences for the ill aged, excluding payment for hospital care for the previously institutionalized and non-institutionalized elderly welfare client.

Medicare is a prepaid insurance program administered through the Social Security Administration for all persons over 65 when their medical needs require hospitalization. One can only assess the adequacy or inadequacy of Medicare-Medicaid legislation and program implementation based upon an intimate knowledge and experience with the clinical realities of the disease and dysfunction of the aged individuals who suffer with the usual multi-organ pathology commonly encountered in the octo and nonagenarian.

The hallmark of effective, high-quality care for the ill aged relates to the delivery of comprehensive treatment processes directed to the support of or the compensation for a variety of concurrent psychiatric, physical or social disabilities. The usual instance of the 80–90 year old person suffering with a variety of progressive diseases related to the nervous, cardiovascular, renal, gastrointestinal, musculoskeletal and sensory systems, together with disabling anxiety, depression, psychosis and senility, in an endless variety of combinations. All the above is engrafted upon a life-long history of personal successes and failures. The latter may be the loss of a child; an unhappy marriage; impaired relationships with parents, now dead; other losses in their childhood; business losses throughout life; sickness and deaths during the course of their life span, not excluding dislocation from their social environment as neighborhoods change and they continue to live in islands of increasing isolation. Also, long-standing family schisms, competitions, rejections and hostilities, long unresolved, may surface in the later years of a person's life span when physically and emotionally vulnerable. In the ill institutionalized aged patient, disability is reflective of a summation of life-long losses, together with the more recent loss of role, influence, job, home, etc. It is within this context of the natural history of man's lifespan that acute illness may precipitate admission to a local hospital.

On the national level, those 65 years of age and over remain in the hospital an average 10–11 days. Clearly, only the more acute, short term, usually self-limiting disease entities are managed successfully in that short period, if at all. Progressive disability related to the items described above in no fashion can be managed in a 10 day period. Thus, the hospital based nature of Medicare represents an exercise in futility with respect to meeting the major needs of the ill aged person. The hospital based Medicare program merely supplanted or replaced or deflected more economical and conventional hospital insurance plans. But, Medicare did manage to superimpose upon the whole a very expensive bureaucracy to administer the plan, both at the government level, as well as the Fiscal Intermediary level and provider level.

In pursuit of cost containment Medicare legislation, using the vehicle of a severely restrictive definition of skilled nursing care as a criteria for achieving Medicare benefits in the skilled nursing facility, effectively emasculated Medicare as a meaningful health care program for the ill aged. Only 2 to 3 percent of all skilled nursing facility bed days are occupied by Medicare recipients. The average period of coverage for Medicare recipients is 20–40 days. Obviously, in the brain damaged person with associated heart failure, diabetes mellitus, visual and hearing defects, with one or more prior strokes, severely depressed and socially dislocated, a 20–40 day period of coverage is totally ineffectual in meeting the daily care needs or the rehabilitation potential for the patient who has been fortunate enough to gain access to

Medicare benefits. Thus, Title 18 has been totally ineffectual in meeting the actual health care needs of the ill aged, both in the hospital as well as the SNF.

A review of the records of an 88 bed proprietary skilled nursing facility in the State of New York revealed that during the past 18 months there were 101 patient admissions. Only 17 (17 percent) of these patient admissions to the SNF qualified for Medicare benefits because of the severe restrictions of the definitions of skilled nursing care as promulgated by the Social Security Administration.

The total patient days for the SNF for the 18 month period were approximately 48,000; Medicare patient days were only 757, or 2 percent of the total. Seven of the seventeen patients receiving Medicare benefits died (41 percent) during their Medicare covered period. Death occurred between 2 days after admission up to 39 days after admission. In effect, almost all the terminally ill Medicare recipients died within 30 days of admission to the SNF. Obviously, these are high risk, high cost patients who, in days prior to Medicare, died in the hospital. Was this the intent of Congress—to merely shift location for termination in order to achieve a lesser cost of care?

The above is only moderately representative of the facts. Most of the difficult to manage patients (medically and psychiatrically) do not qualify for Medicare benefits in the SNF. Those with organic brain syndrome associated with severe contractures, with recurrent pulmonary and G.U. tract infections, were considered custodial by the Fiscal Intermediary and the Social Security Administration. The profoundly depressed patient, with severe disability related thereto and a recent hip fracture with surgical fixation or other acute illness, who required continuing and intensive skilled care, infrequently qualifies for Medicare benefits in the SNF. Nevertheless, just prior to ambulance delivery of the same patient to the SNF, it was assumed the patient did require skilled care in the hospital from which he came.

Obviously, Medicare legislation promised much to the ill aged and has delivered little. The trauma caused by creating expectations in the ill aged, their frustration and sense of defeat and their inability to achieve Medicare benefits in the SNF, has contributed strongly to impairing an already badly damaged image of the nursing home in our society. Further, while Medicare facilitated greater utilization of the hospital premises for short term medical care of the aged, physicians continued to pursue traditional medical practices for the ill aged patients, whereas long term care needs differ widely from the usual diagnostic and short term treatment practices of the hospital milieu.

Thus, the medical profession had a sparkling opportunity to learn more, to pursue greater involvement in the sustained and long term care needs of the ill aged, yet, discharge from the hospital most consistently resulted in an amputation of continued interest and responsibility by both the hospital and the clinician in the long term care needs of the nursing home aged patient. Too often the Medicare requirement of prior hospitalization for qualifying for extended care benefits compelled unnecessary over-utilization of hospital beds and an increase in cost of care where not required. It should be noted that in the post-Medicare-Medicaid era of SNF operations, a well trained staff of physicians, nurses, physical therapists, occupational therapists, social workers, etc., should be prepared to deliver comprehensive care for acute and chronic illness and disability related thereto, without the use of acute hospital facilities. Hospitals should be utilized in behalf of the ill aged for surgical intervention when necessary, resolution of rare diagnostic entities and in selected instances only, the coronary care unit. In all other instances the SNF, in reality, is a chronic disease hospital and should be self-sufficient, providing continuing care for the ill aged at a cost distinctly less than the usual general hospital.

In general, then, Medicare represents a failure of public policy, all good intentions of the government to the contrary. As in most issues involving human affairs, black and white is best avoided. Some of the positive contributions of Medicare were that it permitted and encouraged entry of the ill aged, who too often have lived alone, into the health care system, not to be lost once again to inhumane, indifferent treatment by themselves, their families or their communities.

The hospital system, essentially acute care oriented, has been reintroduced to the health care needs of the aged and thus, constitutes a trigger for the education and reinvolvement of the great medical and nursing professions and other ancillary providers of care into this long neglected area of human need.

Medicaid legislation mandated medical care for the medically indigent in 1965. Medicaid was an extension of previous welfare programs with medical orientation, such as OAA and MAA (Kerr-Mills), Hill-Burton Legislation (1957) and FHA financing of proprietary nursing homes (1959), which set standards for new construction of nursing homes, (the forerunner also of the Life Safety Code for institutional environmental safety). These markedly improved environmental requirements were subsequently incorporated into Medicare-Medicaid requirements. Medicaid, thus, was a

major piece of legislation in behalf of the ill aged, which began to put teeth into criteria for provision of health care services to the ill aged, combined with an improved physical environment in order to facilitate improved professional services as well as the quality of life for the institutionalized aged (the ECF, the SNF and later, the ICF).

One should view Medicaid in the context of what preceded 1965: Long term care of the ill age literally existed in the dark ages of American geriatric care. Physicians and nurses enjoyed no professional esteem in working in a nursing home. Too often the term "neglect" was used as a synonym for custodial care during the pre-Medicaid period. In reality, the rampant poor quality of care was generally due to professional and societal ignorance with respect to the needs of the ill aged, rather than to cruelty or neglect. Neither medicine nor nursing were professionally equipped to either identify or meet the daily needs of the ill aged who inhabited nursing homes or other long term care facilities in the pre-Medicaid period. Certain glaring deficiencies are readily remediable:

a. Removal of requirements for hospitalization to qualify for Medicare in the SNF.
b. Reinstitution of family responsibility for financial support of their ill parent.
c. Resolution of issues relating to custodial versus skilled care.
d. Removal of the ICF category of health care from the institutional arena—it is a clinically untenable distinction.

Medicaid represented a tremendous advance in long term care of the ill aged for those with and without rehabilitation potential. Medicare and Medicaid for the delivery of chronic care to the institutionalized ill aged brought together for the first time in a meaningful fashion, the physician, nurse, physical therapist, occupational therapist, recreational therapist, dietitian, social worker and administration on an institutional level. The team approach to the rehabilitation process for the chronically ill aged was mandated. Absent, however, was the professional expertise to deliver efficient, effective management of the team effort in behalf of the ill aged. With societal guilt escalating on the conduct of its affairs with respect to its ill parents, in the presence of deficient professional delivery of services, the nursing home was vilified and scapegoated by society and the very professionals who failed to function at a higher level. The recognition of professional deficiencies, medical and nursing, as well as social work, were deflected by financial scandals in long term care. The virulent scandals in which funds involving less that 1 percent of the total cost of long term care in this country were displaced, misplaced or misappropriated, obscured the fact that, in reality, under Medicaid auspices the quality of care delivered to the institutionalized ill aged in this country was actually improving sharply. Notoriety took precedence over the increasing competence of providers of care all over this country.

For all of Medicaid's defects, and there are many, it remains a major, significant forward stride in meeting major economic and therapeutic challenges in long term care of the ill aged in our society. It provides sustained and continuous care over prolonged periods in later life; it provides a structure for continuity of care involving nursing home and hospital. The staff patterns required by Medicaid legislation at least recognizes the complexity of care required by the aged, namely, medicine, nursing, physical therapy, and other professional and social support systems.

The modern SNF, which is now able to provide diagnostic, as well as treatment services, is essentially a chronic disease hospital. The nursing home title is a misnomer and a vestige from the pre-Medicare and Medicaid period when the nursing home was essentially a "nursing" facility. The nursing home as a nursing facility must disappear since the complexity of services are far beyond the abilities of the nursing profession alone. The idea of the chronic disease hospital encompasses a totality of services which constitutes the sine qua non of care required by the institutionalized ill aged.

The overwhelming concern about cost of care, the adverse public relations of the nursing home by those who profess sympathy for the institutionalized ill aged, but who, in reality convey their rejection, denial and fear of the psychiatrically ill aged, has obscured the major deficiency of long term care in this country. We have a desperate need for a better trained cadre of physicians, nurses and other professionals who can meet the needs of the institutionalized ill aged. The current expanding involvement of medical and nursing schools in geriatric care gives promise that in the next 5–10 years we may be entering a golden period of American geriatric care. We should spend less time struggling with the nature of sponsorship of long term care—voluntary versus proprietary; less concern for dollars spent in behalf of our ill parents and grandparents, and much more time in creative management and delivery of better quality care and better quality of life to the aged of our society who built this great country, and to whom we owe a great indebtedness.

For all of its deficiencies, and Medicaid has many, much at the bureaucratic and economic management level, everyone seems to be unhappy with cost of care—the government, patients, society, the providers of care, the physician, the nurse, etc., but even as this discontented society vents its frustration, progress has been made via the Medicaid model and should be so recognized. It is a public policy that represents success and a better future for our ill aged.

Dr. MILLER. It is exciting to look back a little bit on the medicare-medicaid experience. Why are we in this dilemma? Is it truly a dilemma? This society has shown itself, in a short period of time, to be able to expand the life of our fellow citizens. But with that great reward certain problems evolved, namely: Increasing disabilities of old age, physical, emotional, social and economic problems. The latter group survived the great health challenges of 40 to 50 years ago.

Whoever dreamed that sulfur drugs, penicillin, streptomycin would produce not only short-term survivors, but those who were rescued in early life from pneumonia, typhoid and tuberculosis, survived into their eighties and nineties, bringing with them the profound problems of degenerative disease and undreamed of psychosocial, familial, economic and demographic challenges for which we were unprepared. Thus we are now trying to resolve some of the problems we inherited from the great medical advances of 40 years ago.

Medicare title 18 was a dream not built on clinical realities. The person over 65 who goes to the hospital—and I am particularly concerned about those who are over 75 years of age and over—is often severely handicapped. They have major multiple handicaps—stroke episodes, heart disease, diabetes, renal disease, arthritis, et cetera. The latter disease entities often coexist in one individual. These people are not only physically sick, they not only lose control of their faculties, but they are also socially dislocated and often alienated from their families, who have disappeared in the true American way.

I don't agree with those who say families remain intact and support their elderly. That is not what I have seen. There is increasing alienation of the American family. As we know, we are dealing with problems of major social significance. We are a mobile society. Marriages do end in divorce. Sexual permissiveness when married and/or unmarried, blurring parental roles, all places the ill aged at greater risk.

We think that only the young of today have multiple marriages. Mr. Chairman, I am fascinated that in our nursing home population at least a third or more of our patients have had multiple marriages. I thought my grandmother married forever. She did marry forever, as did my grandfather—who was married four times.

In multiple marriages, however, when there are siblings of multiple marriages, one finds major family schisms, competition, rejection, cold war—and not so cold at that.

If you can't like your mother and father when they are young and well, what makes one think we are going to love them dearly when they are old and sick, particularly when they don't recognize us and they are incontinent? They are consuming nonproducers. That is a fact of life.

The system we are talking about is predicated on that type of human experience. We speak glibly of the quality of care. What is it? I hardly know what quality of life is for those well and healthy. How can I spell it out for the disabled, the sick and those whose death is just around the corner?

We speak glibly about the good life. When I say I want to live better, the assumption is I know what I am talking about. In fact, I don't.

We speak about good quality of care. Congressman, I have struggled with that. Is good quality of care by a physician to help a person live longer, disabled, struggling, feeling rejected and unable to cope with society? Or, is good quality of care to help him die faster? Or, slower? I don't know those things at all. But, until this society resolves those major societal and cultural issues, we will struggle in medicare and medicaid with where we are going, why we are going and with how we are going to get there.

With title 18, when the elderly who are already profoundly ill experience an acute episode of illness and go into a hospital for 10 days, you and I know it is unlikely the hospital can make a meaningful contribution to that person in a 10-day period. It should be noted much acute illness is self-limiting and requires no special treatment in many instances.

Title 18 was the vehicle of entree into the health care system. I have no objection to that as long as the impact is understood. When the patient subsequently applies for medicare benefits in a skilled nursing facility it is nothing less than a travesty that only 3 percent of all long-term patient care days are covered by medicare. These old people who are profoundly sick and disabled require continuing skilled care of a comprehensive nature and because of the spurious qualifying limitations of the skilled nursing care definitions the vast majority are excluded from posthospital title 18 benefits.

I have heard the term "skilled care" here, but nobody has defined it. It means that care which is resultant of the interrelatedness of the full gamut of medical services—PT., OT., dietetic services, nursing services, recreational services, pastoral counseling, et cetera. Where can a patient get that outside of an institutional setting? Home care? It can't be done because of the obvious lack of trained personnel and the logistics related thereto.

The profoundly ill octogenarian enters a skilled nursing facility out of the hospital. He applies for medicare. Only 17 percent of those admitted to our facilities qualify for medicare benefits and receive only 3 percent of total patient care days—hence those that do receive benefits, only receive them for a very short period of time—20 or 30 days. Why is that happening? Obviously these patients have been chronically disabled for a prolonged period and will be so for the remainder of their lives. As a result, title 18 becomes meaningless with respect to contributing to their life course.

The reason that is occuring in this country is because the definition of skilled nursing care is capricious and fraudulent with respect to the professional services required. The definitions were designed to deny care to those who most need it. Congress intent with respect to title 18 has been effectively emasculated.

The majority of our patients, as well as those all over the country simply cannot qualify for medicare benefits under the prevailing contract written and adopted by the Social Security Administration, which, in effect, has disenfranchised the majority of sick elderly citizens in our country.

When you are confronted with all the severe combinations of patient disabilities, what is 20 or 30 days in the spectrum of what that person has to face during the remainder of his life span?

I have painted a picture of medicare, as it currently exists in this country, representing a failure in national public policy.

In title 19, I see a program that has been most successful in spite of its many deficiencies and I will mention some of them to you.

One must harken back to what preexisted 1965. We had welfare programs prior to title 19. We had nursing homes in operation prior to 1965. They were the dark ages of medical care for the aged in this country. The level of care was horrible. There were untrained nurses, unprepared physicians. PT, OT, and social work services were virtually nonexistent in the premedicaid era. Medicaid really mandated, by social consciousness, by government fiat, that the poor elderly who were severely ill had a right to comprehensive care. Conditions of participation of the Social Security Administration described the coordination of the required professional services on the nursing home premises. It is a most exciting and creative program in "biological-social welfare."

Prior to 1965 the ill-aged had a past only—no future. Under the provisions of title 19 there is a future for potential recovery of function for even the severely ill indigent aged.

Medicaid has been a successful program for the disenfranchised institutionalized ill-aged. Title 19 provided a health care system where they could at least get decent care far better than in their own homes, all the deficiencies of the nursing home notwithstanding. Some of the poorest nursing homes are significantly better than the private home from whence the patient came.

Walk into an older person's home who lives alone. You will see the newspapers 25 years old. You will see the burn marks on the stove; no food in the refrigerator; no change of sheets; urine all over the floor; feces all over the floor; bolted doors. The private home of the ill aged too often is a snake pit. Title 19 remedied that deficiency for the financially indigent.

In their own homes, when they do sustain a fracture of a hip they lie on the floor and are saved by an elevator man or a neighbor and then die out of sheer neglect. That is the way it was. Title 19 has made vast inroads into that sordid picture.

So, I come to you today in 1980 with a mixed story—good and bad. Title 18 is a failure; title 19 a success, notwithstanding certain deficiencies.

I wish to bring certain items to your attention. I believe the current strains in the title 19 program are probably a maturation process. They are remedial. I have studied your suggested solutions, Mr. Chairman. I think they are workable. I heard an ingenious idea from Mr. Cohen about paying for malpractice insurance as a sweetener for the physician who would accept assignment. I think that has some merit. I don't know which I prefer. I think your program and his should be explored further.

Each of your items listed under solutions are all a positive contribution with the exception of No. 5 which states:

> With respect to intermediaries, Chairman Pepper recommended reducing the number of such firms and weeding out those who are the least efficient. He suggested that HHS experiment with incentives as well as fixed price contracts as an alternative to the cost-plus reimbursement system which Medicare uses at present.

No matter what you do the present system will fail. It will fail because your criteria for qualifying patients for title 18 are wrong and not workable. As long as you use the current definition of skilled nursing as a requirement for title 18 benefits this program is a dead duck and not at all useful for the ill-aged requiring nursing home care. The definition also excludes skilled care for those with profound behavioral disabilities—senility and depression—a major cause of disability and dysfunction of the aged.

What is the right program? Let me give you an idea. What does a nurse do that is important? Nursing diagnosis. Can she be trained to recognize a changing medical situation, not only heart disease—it applies to the interrelationship of physical, emotional, and social disabilities. The etiology of much disability of the aged remains illusive. We also see patients getting better when the family disappears. We see patients stop eating after a family visit. There is something in that relationship that is inimical to both. Thus, the ability of the nurse to comprehend patient-family interaction is of profound importance.

I expect the nurse to understand and identify changing patient functions with nursing diagnosis. I expect her to know more than she currently knows about geropharmacology, since most of our nurses are trained in local hospitals and related hospital techniques. Congressman, it takes us 3 years to retrain them in the long-term care facility to meet the nursing needs of the chronically ill aged. They simply are not prepared to handle our patients. Bear in mind, our patients are psychiatrically ill and cannot express discomfort. They don't express nausea. This is not usually well understood by the average nurse.

Our patients who fracture hips rarely express pain. They have coronaries and seldom describe pain. The usual symptomatology of heart failure are not seen at bedside. The skilled geriatric nurse, on a practical level, is at variance with the official definition of skilled nursing care as set forth by Social Security Administration.

The average nurse is particularly unprepared in nursing psychiatry. It is assumed every aged person who behaves bizarrely is senile, that is not so.

Community hospital-based physicians and nurses are not well trained nor motivated to manage on a sustained basis the patient who has been depressed for 30 years or more and who has diabetes with failing vision, one or more strokes, heart failure, and bowel problems, such as diverticulitis. The definition of "skilled nursing care" does not apply to the nursing techniques required.

The usual colostomy patient in the hospital is one situation. The nursing home patient with a colostomy is frequently brain damaged, creating a major social problem. We need nurses who understand that. We need skilled nurses who understand the issues of family counseling. There is no way of providing quality care for an

old person unless the nurse comprehends and can manage patient-family interaction.

Therefore, we need nurses who understand family counseling and nursing research. There is no sense doing the same thing we did 40 years ago. We need something better.

The CHAIRMAN. Doctor, this is tremendously interesting but we have another panel here later. Will you give us your recommendations as to what improvements or changes should be made in medicare or medicaid?

Dr. MILLER. Here are some issues. Hospitals throughout the country are complaining they have nursing home patients locked up in their beds. The issue is very clear. Pay half the amount of money you pay the hospital to the nursing home and we will move those patients out of the acute care setting. Simultaneously, you will save hospital beds, decrease the cost of chronic care, and provide a better level of care for the ill-aged than the general hospital can offer.

There is the issue of present covered benefits. Mr. Congressman, medicare excludes the patient who is totally disabled for reasons already noted.

In order to qualify for medicaid, transfer of patient assets should require at least 18 months before medicaid eligibility.

One of the real serious deficits of the total program was relinquishing of responsibility by families for financial support of their parents. That was 5,000 years on the books of the Judeo-Christian culture; children were indeed required to support their parents, and in the process, family ties and the social unit were strengthened. Families should participate in the financial support of their ill-aged parents.

You have heard so much about alternatives to institutional care. Gentlemen, I know how you feel about home care, but one of the great alternatives is to make institutional care better than it currently is. The only alternative to institutional care for the severely ill aged is another institution; namely, home care; only poorer and less coordinated. That is what you are going to go down the road to, so I say to you, for those people in our society who eventually come to a nursing home, make the institution better. Stop vilifying it; stop distorting the image of an important health care resource. Identifying the nursing home for what it is and must become—a place where we can live longer and remain consistent with the disabilities you come in with.

Fiscal intermediaries—they do their best. They are simply untrained. We are bringing to them issues of the most complicated kind. Our patients are mentally, physically and socially ill and the fiscal intermediaries are clinically untrained to comprehend these issues. We go to the telephone and ask them for their opinion and they read back to us the criteria for skilled care. They are technocrats and bureaucrats doing their job. Humanitarianism is foreign to their consciousnees.

Medicare/medicaid, as you know, is implemented by States. Who implements? Physicians, nurses, OT's, PT's, who are basically untrained in clinical geriatrics.

I would suggest that all who work for the State or Federal Government in behalf of the ill aged spend 6 months in a nursing

home to learn the nature of the problems firsthand before attempting to resolve problems foreign to them. Right now we have a disaster, but it is remedial. But, I wouldn't hold back the program. It must go forth as it is. Title 19 is a significant contribution, but it is limping—it can be made better.

I heard two of the planning and policymakers of our generation this morning, but they have not really emptied a bedpan and they don't know what it is to feed a patient who spits food in the face of the nurse. They haven't cared for an old person who wants to die. As for quality of care and patient's rights: Who am I to insist that a patient who is 90 and who is voluntarily pursuing a premature death course, continue to live? How does a physician pursue the traditional mandate to extend life? I would suggest the planners and policymakers—those in this room—spend some time with us at the bedside level and learn of the clinical realities and convert those realities into meaningful plans and policies for our aged sick.

I would say to you that all involved in long-term care of the ill aged, all administrators, physicians, nurses and others, must be trained together. We are now fragmented. The social work school knows little about the realities of medical and nursing practices in long-term care. Medicine, as you know, is now in hot pursuit of a humanitarian plan of care in addition to the usual technology. I would say, if comprehensive care is to be a reality, we all have to be trained together on the same premises at the same time so that we can work in a meaningful team organized effort in behalf of those patients we serve.

As physicians progress through medical school, at some point they must learn to become physician-managers in order to provide the leadership for the provider of care if quality of care and life is ever to be achieved for the ill aged.

I know my time is up. There are issues on levels of care that must be addressed. Congressman, there is no way to define levels of care until we learn to assess patient disability. We are experts at identifying disease. That is how we are all trained. Very few of us understand the interplay of disease and dysfunction in the elderly.

We don't cure the older person—we don't cure chronic disease. We try to help him with his disability, which is an expression of his total functional capacity.

We must learn how to assess the nature of our clinical material before we place patients in an unsupervised home care arrangement. The latter will be only another place where you put old, sick people, but without supervised professional services—it will be expensive as well. I have made a plea for better trained professionals as direct patient providers, and in the bureaucracy if title 19 is to achieve its full potential.

The CHAIRMAN. Doctor, the nursing home is a very expensive institution.

Dr. MILLER. So is living.

The CHAIRMAN. Running, I should say, roughly from $800 to $1,200 or $1,400 a month.

Dr. MILLER. Yes, sir.

The CHAIRMAN. In respect to the elderly particularly is there any way you can suggest we can devise an institution which would be less expensive for the elderly person for those who pay the bill

than the ordinary nursing home? Could we get some kind of custodial home where there would be proper living opportunities for board and some medical care, the kind that would be needed by the individual, without it being as expensive as the ordinary nursing home is now?

Dr. MILLER. I do not mean to be facetious, Mr. Congressman, but I have spent my life at this. If you tell me whether you want old people alive or dead, I will give you my answer. If you want them alive, if life is priceless, it will never be cheap. If you are as willing to accept that custodial care means neglect, because that is what I believe it means, and if you are willing to accept that custodial care is a method of precipitating premature death, I can make it very cheap. But, if we hold life as precious we must be prepared to spend on the rainy day—the latter for the sick aged is here and now.

The CHAIRMAN. So there is no custodial home that will provide adequate care to the elderly except the present nursing home?

Dr. MILLER. Custodial institutions, in my mind, are simply an obscure way of identifying ignorance, indifference and a lack of understanding of where you want to go.

I know you mentioned the word "preventive" before. What is the man talking about, I was wondering? I don't know how to prevent cancer. I can't prevent arthritis. You can lower blood pressure via pills today. I can't prevent diabetes. What are you preventing? Well, we don't prevent much in the way of somatic disease, but there is one area where you can prevent something; namely, emotional disability. The aged person, by and large, is a combination of the emotional, psychological, psychiatric, and social problems which he has never been able to cope with. That, by the way, is potentially preventable, but requires the most skilled hands to help a person achieve a better life than anything you will ever encounter in a custodial arrangement.

Depression at the age of 30, 40, 50, is the harbinger of profound disability in the aged period 30 years down the road. That, I believe, is preventable. We have seen that repeatedly. That can be done, but that requires exquisite skill and it is expensive. But, is not that worthwhile?

Certainly, I wouldn't put my mother or father in the hands of untrained, unskilled people—custodial care—when the issue of their future life is under consideration.

The CHAIRMAN. Thank you very much, Doctors. You have given us an animated and eloquent and very, very valuable analysis of the problem and some very, very valuable comments.

So Mr. Bonker, do you have any questions.?

Mr. BONKER. No questions.

The CHAIRMAN. Thank you very much, Drs. Kassel and Miller. We appreciate the way you have spoken off the cuff here in summary form and you have given us right out of your heart and long experience some very valuable suggestions.

Dr. MILLER. Thank you.

Dr. KASSEL. Thank you.

The CHAIRMAN. Now our last panel is comprised of senior citizens who have experienced difficulties with the medicare program and have come to share their observations and concerns with us.

I would like to welcome Miss Bertha Wolman of Washington, D.C.; Mr. Lawrence Hibbard of Rochester, N.Y., and Mr. Raymond Reul of Cocoa Beach, Fla.

Thank you all for coming. Will you come up and have a seat at the table?

Mr. BONKER. While the witnesses are approaching the table, I would like to make a few comments.

I have had four different meetings this morning and felt this was the most important. That is why I have been here, but I do have to rush on. I have read the statements of each of the upcoming witnesses.

Mr. Reul, who is from Florida, wants to find a new agency to replace Blue Cross, I have read your comments about the problems you have encountered there.

Then Mr. Hibbard wants medicare expanded to provide for drugs as well.

And I have read the last one, encountering problems with claims.

Mr. Chairman, I find that these witnesses put forth information that confirms what this committee has already discovered, that is, the enormous problems in administering the medicare program with its many restrictions, limited coverage, and the cumbersome way in which the whole program is administered. I am going to be writing to you shortly to ask if this committee, under your direction, could set up a task force that could look at some of these issues that really aren't very appealing to the entire committee, but are so important in the day-to-day administration of the program.

We did have hearings in Longview with your consent where we had the highest ranking officials of the Health Care Financing Administration together with a task force of seniors and went over claims, the lack of nursing home beds, and other problems. If we are going to get on top of it through our oversight responsibility, we are going to have to give it some specialized attention.

I would like to have your permission to work with the committee staff in expanding the section on recommendations of the excellent staff report. I feel this ought to be a basis for new strategy to provide extended health coverage for senior citizens. I think we are going to need a document or a basis or a strategy to involve not only much more than this committee, but the very senior citizen organizations and others who are involved in this important question of health care.

I am sorry I have to leave, Mr. Chairman, but I do have a continuing and very deep interest in this subject. I want to thank you again for having these hearings.

The CHAIRMAN. We appreciate the deep interest you have manifested for a long time. Your presence here this morning, when you had other demands on you, and the valuable contribution you are making and will make to this committee—we would like very much to work with you, I and the staff.

Mr. BONKER. Thank you.

The CHAIRMAN. Miss Wolman, tell us what you can about medicare.

STATEMENT OF BERTHA WOLMAN, WASHINGTON, D.C.

Miss WOLMAN. I had prepared my statement in advance but if you don't mind I would like to proceed to read fairly quickly the items that I have.

The CHAIRMAN. All right. You go right ahead.

Miss WOLMAN. I want to commend you, to begin with, you and your staff for your very close attention to the previous speakers.

The CHAIRMAN. We are grateful to have you here. You go right ahead.

Miss WOLMAN. I am Bertha Wolman. I have lived in the Washington-Maryland area all of my life. I worked for about 38 years at the Veterans' Administration where I was employed in clerical and administrative functions as well as a hearing reporter and legal and medical researcher until my retirement in 1956, so I am one of the old gals. Since that time I have been very active in volunteer work at the D.C. General Hospital, Children's Hospital, and currently at the Smithsonian, where I volunteer at an information desk.

I am here today because of my experience with a very sick sister, who died a year and a half ago, and other elderly people whom I have helped in submitting claims to medicare. I, myself, am under medicare too, but I have no particular problems. From my experience, I have found the following problems to be the most pervasive and creating anguish for those who depend so much on medicare.

I might add that the committee is well aware of what I am about to say, but perhaps reiteration by me might emphasize certain points.

The item of medicare premiums and the annual deductible, Mr. Cohen mentioned that the deductible was not a hardship for him. I am very glad that it wasn't. He made an excellent presentation. But that is not always the case. The premiums and deductibles are getting so high that the elderly of low income who do not have supplemental plans will not be able to meet the high medicare costs and will have to discontinue coverage. This might mean food, clothing, or housing to them.

The CHAIRMAN. Let me ask the staff, are the payments made by medicare patients as their deductible contribution conveyed into the fund? Do they become a part of the general fund?

Mr. HALAMANDARIS. No, sir. The patient pays them privately, that is all. The premium is the only thing which goes into the trust fund.

The CHAIRMAN. So the deductibles do not go into the trust fund?

Mr. HALAMANDARIS. No, sir.

Miss WOLMAN. I pay $9.60, I think it is the new current amount since July 1. The newspapers often give the impression that we are getting all of this free. But I am not getting it free, I am paying my share and the Government is paying its share.

The CHAIRMAN. You go right ahead.

Miss WOLMAN. The item of payment for eye refraction tests, which is reduced by medicare—I think the last time they took off $7 from mine. There is no payment allowed for eye refraction tests which may be absolutely necessary for detecting and following the progression of some diseased conditions of the eyes. How you see is very important to the doctor. If you don't see the chart properly

with your glasses, then he can't help you without refraction. It is a very serious thing. We are reduced in that. I do not know whether social security set that rule. Some of this is beyond your jurisdiction, I realize.

The definition of "custodial care," which has been taken up today, in nursing homes is very restrictive. I think custodial care should be assistance in eating, bathing, and washing a patient and assistance in dressing. But the interpretation of custodial care seems to be that everybody in a nursing home who does not require postsurgical care, physical therapy and such, or shows immediate recovery from fractures, and that for a limited time, is considered a custodial patient.

I know from personal experience in my family that this is a very bad hardship; 14 days allowed in a nursing home after severe operations. Reimbursement for nursing home care is too small an amount and too short a time as contrasted to hospital coverage. I personally don't know anybody who got full nursing coverage as specified in my medicare booklet. They would be cut off sharply 10 days, 2 weeks, maybe 1 month; none of them have gone on to the full amount.

Most people covered by medicare are under the impression that it will cover some nursing home care for severe illnesses. I know that myself. They think that all illnesses are covered by medicare, but they are shocked to learn they may have little or no coverage because most care is considered custodial. Many are ill-prepared for a long, expensive stay in a nursing home and end up depleting their life savings for care they thought would be covered by medicare. No consideration is given to the advanced age and general physical fitness of the patient admitted after operations or severe illness.

In the case of my own sister, she was very, very badly crippled by arthritis. She walked at home with a walker, previously with a cane. She had very poor eyesight. At the time of her death she was legally blind. She had had a severe hemorrhage of the eyes. After her hip was broken one time, her wrist broken another time, naturally a woman in her eighties would take a longer time for recovery than the average person—but they didn't allow that. They gave her a very brief period.

Reimbursement checks from medicare are attached to the explanation of medicare benefits form. Although it is stated below that it is a check, many elderly people have poor eyesight and do not realize that this is a check and they discard the check along with the notification. To them a check is a different kind of paper and should look like a check. That I have seen from personal experience.

I helped at the YWCA when the bus passes were issued and they had to give proof of their age, either medicare or birth certificate. A woman came along whose explanation of medicare benefits form was dated months or a long time before, and the check was nicely attached at the top of it; I asked her what that was doing there. She didn't know it was a check. She had discarded previous ones.

Then I started asking people. That was fairly common; they didn't know they had a check. The time I called medicare and told

them that I thought checks should be in a different form than that, apparently it didn't register.

The brief information on the explanation of benefits allowing or disallowing the claims is confusing. It may seem efficient and clear to the person who designed the explanation but to the uninitiated or sometimes ignorant elderly person, it is meaningless. They will have various designations; see the back, see the front, see the side.

My sister, who was a pretty bright person, pretty smart, these things confounded her. She simply could not understand. She would be on the telephone in Silver Spring and I would be in the city, and I tried to explain to her what it meant. But I would have to go out there and look at the form and explain it to her. So I know that from personal experience with her and with others.

When I mentioned this to somebody else, not a medicare claimant, it was suggested that there could be a special 800 number of the nearest social security or medicare office which the person in rural areas or small cities could use. We in the city may call that phone any time. I use it a lot.

The manner of filing certain types of claims may be suddenly changed without notification to the claimant. For example, sudden discontinuance of the yellow carbon copy of the explanation of medicare benefits. For years they sent a yellow carbon copy which we used.

In the District of Columbia, under the Federal employee program, Blue Cross/Blue Shield, which I use, when the claim is for laboratory fees or surgical fees, basic part A, medicare will send the necessary information to the Blue Cross office for my claims. But when the claim is for an office visit to my doctor, part B, they do not do this. I didn't know this at first. They suddenly discontinued the use of the yellow form. But on my inquiry, over my telephone, I found out what was happening.

To file a claim for my supplemental benefit, I must send my original explanation of medicare benefits form, with the claim, with a copy of my doctor's bill, leaving me with no explanation form, or I must go somewhere at great inconvenience to get a Xeroxed copy to keep in case of loss, which has sometimes happened, making me file a second claim with Blue Shield.

This, to me, is an important point: insufficient policing or investigation by medicare before payment of hospital bills. My sister had very good coverage. Medicare was very kind to her, gave her good reimbursement. But I think outright padding of bills, with big profits to the hospital, or coverup of duplicate charges for example, between the hospital and the pathologist, sometimes is done.

For instance, a pacemaker to be used for a medicare patient. Three months before my sister died she had a pacemaker installed, which I thought was ridiculous, since there was no hope of recovery. But the doctor decided a pacemaker should be inserted. When the hospital's statement came—there was no bill, medicare paid for all that—there was an enormous charge for the pacemaker.

I checked around different places, I do not remember exactly where, and found they had overcharged. That is not the doctor's fee, that is for the pacemaker alone, which my taxes and your taxes will pay. They had overcharged by at least hundreds of

dollars, this particular hospital. I do not know who checks the hospital's fees, but I thought this was too high.

Medicare will not accept claims for injections or inoculations even though the injections or inoculations are treatments for some diseased conditions. For example, a friend of mine—she had shingles from the waist to the knee—received a chickenpox vaccine inoculation as a treatment to stop the spread of shingles and this was disallowed by medicare. Her doctor said that was a good treatment. It didn't cure it but it stopped the spread of it. This was disallowed because medicare did not allow for inoculation. Injections might be needed in the case of a severe anemia where you need B–12 shots. They don't allow that either.

When a doctor files a claim for a patient, either the doctor's office sends a blank form to sign and return, or the patient signs it in his office to be completed by the doctor—the patient does not know what information is placed on the form—or the patient signs a blank form, which I do not think is quite ethical.

When the claim is paid, if a doctor has not accepted assignment, and he usually does not, as was said here today, the patient receives the medicare check. When the doctor accepts assignment and receives the medicare check, the patient is supposed to receive notification but many times does not. When you have a supplemental program, this causes a lot of confusion because you must submit that explanation of medicare benefits with your supplemental claim.

A friend of mine has been in and out of hospitals and nursing homes for several years, and is now in a nursing home, I helped her for 3 years in my apartment building. She was the most complicated medical individual, medically treated individual I have ever seen. She had everything and she had it severely. She is now, I think, terminally ill in a nursing home.

She lives here, no family, her only son lives in another State. He called me on the phone Sunday to find out how she was doing. I told him I was expected to come here and did he have any suggestions? Of course, on the phone that is a little difficult, but he exploded because he has been handling her claims now, 1978, 1979, up to now, and he has been trying to work out his mother's benefits and it has almost driven him crazy.

He had a few comments he wanted me to pass on to you, one of which is, a great problem arises when a patient crosses State lines or jurisdictions. After two severe operations he took her back home for a while, tried a nursing home. I think medicare gave her 10 days' coverage. When he took her home, he hoped to take care of her. She was partially paralyzed, she was a mess; he couldn't handle it, poor fellow, he was working.

The intermediary was changed at that time, too. So he finds inconsistencies in payments. Sometimes a claim is denied which is exactly the same claim which had been previously paid. This entails a long process of appeal. Sometimes claims are delayed for months, settlements for hospital bills can take up to a year.

This mother now has a gastrostomy opening, she has a jejunostomy opening. She can't talk, her throat is partially paralyzed. Nobody can take care of a patient like that at home. Yet they

considered her after these operations, now under custodial care. It is not custodial care. But she didn't get full nursing home benefits.

Thank you very much for listening to me.

The CHAIRMAN. We appreciate very much your being here.

Miss WOLMAN. I appreciate very much what your committee is doing.

The CHAIRMAN. Thank you.

After we have heard the three of you, I am going to ask the staff to make a summary of the various suggestions that have been made and send them to the medicare authorities with a view to their taking note of the recommendations that you have made.

Miss WOLMAN. That is a very good idea.

The CHAIRMAN. We must move along now.

Mr. Reul, we would be delighted to have your statement.

If any of you can put your statement in the record and summarize it orally, it would save us time and save you time. I want you to have a full opportunity to tell us what you came here to tell us.

STATEMENT OF RAYMOND REUL, COCOA BEACH, FLA.

Mr. REUL. Mr. Chairman, members of the committee, ladies and gentlemen, I am Raymond Reul. Prior to my retirement I served as coordinator of industrial engineering and systems engineering programs for Food, Machinery & Chemical Corp.

Since I have retired I have formed an organization called Merit Consulting Service, and I today lecture internationally on management systems. I reside with my wife in Cocoa Beach, Fla. I have a few comments to make before I get into my prepared statement.

My presentation is in connection with medicare part B only and specifically as to how Blue Shield of Florida's atrocious management of processing has cheated endless numbers of senior citizens out of reimbursements that have been authorized by medicare but which they are not receiving.

Much of the testimony that has been presented has stressed the low percentage of reimbursement of senior citizens and the refusal of so many doctors to accept assignment.

I would like to argue that the problem of the medicare program is not that the program doesn't approve enough, but it is the poor administration of Blue Shield, who is the contractual carrier in Florida, all except for the two southern counties.

I first became interested in doing something about the inadequacy of our medicare part B reimbursement system in 1977 when Blue Shield of Florida sent me $230.55 as reimbursement for a $410.40 bill or 56-percent reimbursement for laboratory tests that were performed on my wife while she was hospitalized following a near fatal heart attack. This sum did not come close to what we had expected would be paid by medicare.

My first request to medicare for review went unanswered. My second request was refused because it was now more than 6 months since the EOMB was processed. I was told that a review request had to be filed within 6 months after the claim was processed.

My wife had another heart attack in January 1980, and was again hospitalized for about 2 weeks. This time Blue Shield of Florida sent me $220.65 as reimbursement for a bill of $543.80, or 40-percent reimbursement. This time I was prepared. I sent copies

of my Blue Shield review requests to my Congressman, Bill Nelson, and his office wrote to Blue Shield, too. I next tried to obtain the codes by which they identify these medical tests on the computer printouts, which are called the EMOD's—explanation of medicare benefits—in order to check what services were and were not reimbursed by Blue Shield. Blue Shield repeatedly refused to send me copies of these codes. I eventually obtained them from the office of a doctor disgusted with the performance of Blue Shield of Florida.

I sent review request after review request to Blue Shield, pointing out specific errors, including items omitted from processing denied because of false claims of duplicate items, and incorrectly coded services, so that the payment was smaller than it should be. The end result was the receipt of 29 EOMB's, 29 garbage computer printouts, which contained corrections of some of the specific errors I had pointed out, plus other errors that included payments of some claims as many as three times.

Finally, I received a letter from Blue Shield stating I had received $554.20 on the $543.80 claim, or $10.60 more than the whole claim on which I was entitled to only $418.10 remuneration, and therefore received an overpayment of $136 which I must remit at once. I pointed out some still uncorrected errors and received a second letter stating that the overpayment to be returned was now reduced to $82. By return letter, I pointed out an arithmetical mistake that would make the correct overpayment $61.

I then received a second notice that the overpayment was $136 and must be returned or there would be penalties, including an adjustment to my social security benefits to reflect the overpayment. None of these overpayment claims were documented with correct explanation of medicare benefits statements.

With the knowledge and experience I gained in seeking redress on this bill, plus the help of Congressman Bill Nelson's office, I finally got Blue Shield to reopen review of the previously discussed 1977 bill, correct coding errors I pointed out, and reimbursement increased from $230.55 to $313.55, which is now a 76-percent recovery.

I doubt that many senior citizens would have the skill, the will, and the determination to identify all of these gross Blue Shield errors and thus would have suffered the loss of a major portion of their medicare part B they have paid for. I am well qualified for this kind of effort and believe I have obtained most of the reimbursement to which I am entitled, but believe I have documented a high probability of a widespread ripoff of many senior citizens by Blue Shield's poor performance, if not deliberate fraud. Yes, they have been saving money for medicare but at the expense of senior citizens.

There are two indications of possible fraud:

One. The observed erratic random order of selection of items from supplier's invoice to post EOMB's makes auditing extremely difficult, if not impossible. Despite repeated requests for explanations of this procedure, none have been received.

Let me explain to you what I mean by erratic posting. Consider the invoice from the supplier here, consider the computer printout. You would find that the first item on the invoice was the seventh

item on page 2 of the printout, the second one was the fifth item on page 1, the third one was the ninth item on page 2, and so forth.

This made auditing almost impossible. If I had not obtained a set of these codes which Blue Shield absolutely refused to send to me or to our public library librarian—but which I obtained by an indirect method from a disgusted doctor, I would never have been able to find these errors, even with my expertise.

Two. I placed a copy of the laboratory test codes in the Brevard County Public Libraries and arranged for a letter to be published in the local newspaper explaining to senior citizens how to use them to check their reimbursement from Blue Shield. I learned that Blue Shield's reaction was to send a letter to the same newspaper in which they suggested that patients shouldn't use these codes because their application was so complex that senior citizens would not understand how to use them. They claimed, furthermore, that Blue Shield processing was so accurate and reliable that auditing was really unnecessary.

I have carefully documented every error to which I have alluded and have written confirmation from Blue Shield that the stipulated errors were made and corrected, but only after I identified and insisted that they be corrected.

I would also like to point out that Blue Shield has recently put in an 800 hot line. I have found out they have 30 representatives answering that line, but you have a long wait before you reach anybody, even though they answer it, which means they have at least 40 of these 800 lines. I found out these lines cost $1,000 per month. In other words, they are spending on 40 lines $40,000 a month of medicare money so that you can call them, tell them about the things that are wrong, and then they do nothing about it.

On top of that, they are paying the salary of 30 representatives to sit there from 8:30 in the morning until 5:00 at night and do not give you any satisfaction when you do talk to them. That is almost $1 million a year in my estimate of what Blue Shield is causing medicare to pay for absolutely nothing.

I think the House Select Committee on Aging should make a determined effort to find a new agency to process part B claims instead of Blue Shield of Florida. I suspect that a simplification of the processing procedure specified by medicare, along the lines that you have suggested, Senator Pepper, would do much to improve this situation. Failing these, may I suggest that the establishment of agencies to help senior citizens audit suspiciously low reimbursements should be seriously considered. These could be volunteer, grant-supported organizations. I would be glad to offer my personal assistance in this regard.

I wish to offer my thanks to the House Select Committee on Aging for the opportunity to bring this to the public's attention.

[The exhibits submitted by Mr. Reul follow:]

EXHIBIT I

Sample of erratic random order of processing that makes auditing difficult to impossible

Supplier's Invoice				Explanation of Medicare Benefits				Notes
Page #	Item #	Date	Code	Code	Page #	Item #	Date	
1	1	1/5	85022	85022	2	9	1/5	
1	2	1/5	84450	84450	1	7	1/5	
1	3	1/5	83615	83615	1	2	1/5	
1	4	1/5	82550	82550	1	4	1/5	
1	5	1/5	81000	81000	1	9	1/5	
1	6	1/5	84295	84295	1	11	1/5	
1	7	1/5	84132	84132	1	10	1/5	
1	8	1/5	82564	82375	1	6	1/5	wrong code
1	9	1/5	84450	84450	2	2	1/5	
1	10	1/5	82550	82550	2	1	1/5	
1	11	1/5	83615	83615	1	5	1/5	
1	12	1/5	85650	85650	2	6	1/5	
1	13	1/5	82803	82803	1	12	1/5	
1	14	1/5	84132	84132	2	1	1/5	
1	15	1/5	84295	84295	2	3	1/5	
1	16	1/5	82437	82437	2	5	1/5	
2	1	1/5	86595	86595	2	8	1/5	
2	2	1/5	82374	82374	2	11	1/5	
2	3	1/6	85022	85022	2	12	1/5	Wrong date
2	4	1/6	85650	85650	2	13	1/5	Wrong date
2	5	1/6	85580	85580	1	3	1/5	Wrong date
2	6	1/6	85044	85044	1	1	1/5	Wrong date
2	7	1/6	86031	86031	3	2	1/5	Wrong date
2	8	1/6	84006	84006	1	8	1/5	wrong code. Wrong date
2	9	1/6	83550	83540	2	4	1/5	wrong code. Wrong date
2	10	1/6	84450	84450	2	7	1/5	Wrong date
2	11	1/6	82550	82550	2	10	1/5	Wrong date
2	12	1/6	83615	83615	1	13	1/5	Wrong date

Explanation of above requested.

No answer received.

EXHIBIT II

MEDICARE PATIENTS SHOULD CHECK CODES

(By Raymond I. Reul)

An open letter to Medicare Patients:

Have you been finding the amount of reimbursements allowed by Blue Shield on your chemical and pathological laboratory tests to be considerably less than the amount billed by your laboratory or doctor? It is quite possible that this situation may have resulted from Blue Shield's application of incorrect procedure codes.

You can do something about this! All Brevard public libraries now have, or soon will have, copies of the official lists of these tests and the properly applicable codes. Take your Blue Shield "Explanation of Medicare Part B Benefits" computer printouts (which come attached to your reimbursement checks) and check the procedure code list. If you find any errors (and you are quite likely to find some), mark them up and send a copy of the marked-up sheets back to Blue Shield for review. In many cases these corrections can result in the receipt of appreciable additional reimbursements.

EXHIBIT III

BLUE CROSS AND BLUE SHIELD OF FLORIDA,
Jacksonville, Fla., July 16, 1980.

Mr. RAYMOND I. REUL,
Cocoa Beach, Fla.

DEAR MR. REUL: In the May 21st edition of the Cocoa Today, a letter from you appeared concerning proper reimbursement for laboratory tests. Although we appreciate your interest in helping senior citizens understand the Medicare Part B program, we feel that your letter requires some clarification.

There are various reasons why simply comparing the five-digit procedure codes on the "Explanation of Medicare Part B Benefits" (EOMB) with the Florida Blue Shield Manual for Physicians can be somewhat misleading.

For instance, modern technology makes it possible to use automated equipment to perform several different laboratory tests simultaneously. (Frequently these tests are performed using a single specimen.) It is usually less expensive for a physician (or laboratory) to perform a number of tests in this automated fashion than it is to perform each test individually. Medicare Part B is required to take this increased automated efficiency into account when certain laboratory tests are rendered on the same day. In these cases Medicare B groups individual procedures into a single "Multichannel" procedure. Reimbursement is then based on this "combined" procedure which is usually indicated on the claim by a single five-digit procedure code. It would be difficult indeed for the patient to determine which code or codes most accurately describes the particular series of laboratory tests he received. To correctly group several individual procedure codes into one code indicating automated testing is even more difficult for the patient.

Additionally, the codes in the Physician's Manual are constantly being updated. Chances are that the Manual you refer to in the library will not be current. This would create the impression that an "application of incorrect procedure codes" has occurred when, in reality, the correct revised code was, in fact, used.

In short, Mr. Reul, federal limitations and regulations governing the processing of Medicare claims, the difficulty and expertise required to accurately group several laboratory procedures into a single all inclusive procedure (code), and the unlikelihood of libraries possessing all current revisions to the Physician's Manual all make it very difficult for the Medicare beneficiary to do as you suggest in your letter concerning laboratory tests. (For procedures other than laboratory tests, the checking of procedure codes by Medicare beneficiaries would be appropriate.)

Blue Cross and Blue Shield of Florida—as the administrator for Medicare Part B in most of Florida—does, however, publish a monthly Newsnote to Florida physicians that frequently addresses laboratory claim filing procedures. Because of this and other information regularly disseminated to Florida physicians and laboratories, we feel that most Medicare claims submitted for laboratory tests include the proper procedure code and, therefore, are properly reimbursed in the majority of cases.

If you would like to talk to us about this further, please feel free to give me a call.

Sincerely,

JAMES TUCK,
Communications Specialist.

Attachment.

EXHIBIT IV

COCOA BEACH, FLA., *July 21, 1980.*

Mr. JAMES TUCK,
Communications Specialist,
Blue Shield of Florida, Jacksonville, Fla.

DEAR MR. TUCK: I am quite aware of, and completely familiar with, the "Multichannel" procedure specified by Medicare to under reimburse certain laboratory test billings by always assuming they were performed simultaneously on automated equipment regardless of whether they actually were or were not so performed. Although this procedure is obviously unfair and cheats medicare patients of reimbursements for which insurance payments have been deducted from their social security income, the methodology for the grouping and combining of such payments is clearly spelled out in the "Manual For Physicians" and can be easily understood and followed by a grade school graduate. Furthermore, the application of this "Multichannel" procedure is limited to only 19 of the more than 800 coded tests. I resent the implication that Senior Citizens are too senile to comprehend this procedure.

The copies of the procedure codes which were placed in the Brevard Public Libraries are quite up to date. They were obtained from local doctors, disgusted with the many omissions, miss-codings and erroneous disallowances experienced with Blue Shield Medicare processing, plus the frequent delays of as much as three months between the initiation and completion of processing individual medical bills. These errors had nothing to do with the "Multichannel" ripoff. This source for the codes was utilized because Blue Shield refused repeatedly, requests from myself and Puolic Libraries.

The availability of these codes is essential to every Senior Citizen incurring medical bills and covered by Medicare. Without them, accurate auditing of Blue Shield's "Explanation of Medicare Part B Benefits" is difficult to impossible and review correction of Blue Shield processing errors can seldom be achieved. Use of this code list to audit a recent Laboratory tests bill for $543.40 made possible identification and documentation of processing errors resulting in an under reimbursement of $272.00. These errors have been acknowledged by Blue Shield and the underpayment corrected. But this action was taken only after each of the errors were identified and documented by the patient.

Very truly yours,

RAYMOND I. REUL.

The CHAIRMAN. Thank you, Mr. Reul. You have given us a very powerful statement and we are delighted to have you. Thank you very warmly.

Mr. REUL. I would like to make one other statement. One of our local newspapers is so aware of the fraud that is going on in this area that they are seriously considering placing one of their investigative reporters on a job working for Blue Shield.

The CHAIRMAN. It might be a good idea. Thank you very much, Mr. Reul.

Our next member of the panel is Mr. Hibbard. Mr. Hibbard, we are delighted to have you here.

STATEMENT OF LAWRENCE HIBBARD, ROCHESTER, N.Y.

Mr. HIBBARD. Thank you, sir.

Mr. Chairman and members of the committee, my name is Lawrence Hibbard and I reside in Rochester, N.Y. I am pleased to appear before you today as we celebrate the 15th anniversary of the enactment of the medicare program.

By way of background, I am an attorney. I received my law degree from the University of Buffalo in 1933. For more than 35 years, I was a claims representative for the Prudential Insurance Co. of America. I traveled extensively throughout the country investigating claims and had the opportunity to visit with hundreds of hospitals and medical practitioners over the years.

After my retirement in 1971, I was instrumental in establishing an AARP chapter in the town of Irondequoit, which is a suburb of Rochester. I was the first chairman of the chapter's legislative committee, a post I held until last year.

For about 4 years, I was involved with a program sponsored by the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP) which trains older Americans to help their peers in preparing their Federal and State income tax forms.

Late last year there was great concern in our area caused by the fact that Blue Cross/Blue Shield of Rochester did not seek to renew its contract as the medicare carrier in our area. The contract went to Blue Shield of western New York, based about 100 miles away in Binghamton, N.Y. It was feared that senior citizens in our area would not get rapid processing of their claims at least until the new carrier was able to gear up for the effort.

I was among 15 volunteers in our area who were trained by the Department of Health and Human Services to help older Americans prepare their medicare forms. I completed a 3-day training course and I received a claims manual with instructions on how to prepare the forms so that there would be rapid payment.

It had been contemplated that the volunteers would serve only for a 3-month transition period from October through December, 1979. However, at the end of last year, the problems were continuing. For this reason, our volunteer program is ongoing.

I am given free space in a senior citizen center and I see several clients each month. Our medical assistance program has been supported by NRTA/AARP which has similar volunteer efforts in eight additional States.

We feel that these programs are highly effective even though they have no official sanction and they are run on a shoestring budget. The primary reason that our projects work is because they offer person-to-person contact rather than the cold, impersonal contact of the computer.

In my experience in helping hundreds of elderly persons with their complaints, I would outline the following as the major problems with medicare:

First, delay in payment. I believe that most simple claims should be paid within 21 days. Anything over that time is an unreasonable delay.

Our intermediary pays most claims on a timely basis, and we are generally satisfied with their service. However, you must remember I deal with complaints, and it is not unusual for me to see cases which have gone 6 or 8 weeks or longer without being paid.

Second, senior citizens are not given adequate explanation of why claims are not paid. When a claim is rejected, older Americans should at least know why it has been rejected.

This leads me to the third point. Senior citizens do not know they have a right to an appeal. If medicare returns their bills without paying, most seniors will not question the denial even though they may be entitled to reimbursement.

My fourth point follows: It is a rude shock to many seniors that they have to pay for drug bills out of pocket. I believe the Congress should do something about closing this gap in the program. I find

that seniors will often send their drug bills in to the carrier along with their doctor bills. The carrier will generally not return the drug bills.

There are many seniors who do not keep a copy of their drug bills. The carrier generally disposes of them. This means that unless they keep a copy, senior citizens will not have documentation of their drug costs to deduct from their taxes or to pass on to private insurance.

Fifth, many intermediaries and carriers have a toll-free number. This is a good idea but in our area it does not work too well. I have waited 50 minutes or more to get through on our line. And when I do get through, the personnel on the other end of the line tell me only that they are processing the claim.

Since I get little information, I wonder what the purpose of the toll-free number is. Apparently they can't bring these up on the telephone. They just say we have it, hold the phone and pray and we will get back to you.

Sixth, I would say there is a growing problem in the refusal of doctors in our area to accept assignment from medicare. Perhaps 10 to 20 percent of them in our area—I am speaking of Rochester now—will do so.

Senior citizens feel cheated when they have to pay the doctor out of pocket and carry the burden of filing forms with medicare. This is particularly true if medicare's response is slow and as is often the case, medicare may pay as little as one-third of the bill.

As an example of the kind of case I handle, I want to tell you about my work for Phyllis Snaveley. Phyllis is the daughter of Helen Reynolds who died last August 1979. Phyllis paid her mother's medical bills and sought reimbursement from medicare.

In January of this year, the carrier returned the claims without payment—again with little explanation. I became involved and soon learned that Phyllis had not completed the form 1660 which tells medicare that she is the beneficiary of the deceased.

Since then, there have been several more letters and calls from me. Checks were sent twice addressed to Helen Reynolds, who is the deceased. It should be a simple matter for medicare to send the $147.36 that they owe to the daughter, Phyllis Snaveley. Despite promises to me, she has still not been paid. I would remind you that a year has passed since Mrs. Reynolds died.

Another case involves Andrew Remery who died in a nursing home in Rochester in July 1979. He was admitted with advanced cancer, and nurses certified he needed 24-hour skilled nursing care. He was so weak he could not feed himself and at times could not even hold up his arms.

The carrier has denied payment to the family which spent some $1,600 for his care in the nursing home, a total of 35 days. In my view, there has been no adequate explanation of this refusal to pay.

Someone has informed me that medicare has a regulation which says that patients must have rehabilitative potential, or medicare will not pay for their stay in a nursing home.

When I asked a Health and Human Services employee about this, I remarked that perhaps 1 percent of all admissions to nursing homes would be compensable by medicare if this standard were

applied nationwide. The HHS representative said to me, "I think that's about right."

I might add that I have the permission of both the Remery and Snaveley family to bring these facts before you today.

I would suggest that Congress expand the scope of medicare particularly to cover prescription drugs. You must find some way to encourage physicians to accept assignment. Then I think there is a need for more personal contact between employees of medicare, the carriers, and the senior citizens they serve.

In short, Mr. Chairman, we feel that medicare has been a blessing. We are grateful for it. At the same time, we feel that there are growing problems which must be addressed if medicare is to fill its potential.

I thank you for your attention. I would be happy to work with you to bring about some solutions to the important problem that we have highlighted today.

The CHAIRMAN. Miss Wolman, Mr. Reul, and Mr. Hibbard, you have given us extremely valuable, practical information which will be helpful to senior citizens all over the country.

We are going to make a summary of the recommendations that you have given us here today and submit this to the medicare people to see if we can't be of some help in improving the procedures so that elderly people can be paid more promptly and more adequately.

I apologize to you again that we ran over so long. I am going to ask the staff in the future not to schedule so many witnesses. We are all very much interested in the subject, we want to hear what everyone has to say.

When the committee is here a lot of questions are asked, so it takes a long time. We have been steadily at this hearing since 10 o'clock this morning except for one 5-minute interruption. That is the reason we had to keep you so long. I am sorry we have had to do that.

You have given us valuable information and we appreciate it very much. Good luck. Thank you all.

[Whereupon, at 1:45 p.m., the select committee was adjourned.]

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